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ABSTRACT

The role of nurses within multiagency rehabilitation teams was examined in a 2-year research project that included 3 case studies of a total of 49 clients of rehabilitation programs in the United Kingdom. Data were gathered through the following activities: observation of and interviews with clients, nurses, and other members of the multiprofessional team; a postal survey of nurses; and a record review. The nurses participated in the following aspects of patient care: assessment; coordination and communication; provision of technical and physical care; integration of therapy and therapy continuation; provision of emotional support; and involvement of the family in the client's rehabilitation. Only 36% of the nurses believed their preregistration education provided adequate skills and knowledge for their role in rehabilitation. Specific gaps in the nurses' skills and knowledge were identified. The study documented the scope and complexity of the knowledge base required by nurses on multiprofessional rehabilitation teams. The following were among the recommendations for improving nursing education: (1) base education preparing nurses for work in rehabilitation on a social model of rehabilitation; (2) institute a required nationally recognized and accredited postregistration qualification in rehabilitation; and (3) integrate learning in the workplace with more formal educational provision. (Contains 25 tables/figures and 59 references.) (MN)

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Teamworking in Rehabilitation: exploring the role of the nurse

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English National Board for Nursing, Midwifery and Health Visiting

RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Teamworking in Rehabilitation: exploring the role of the nurse

Andrew Long
Rosie Kneafsey
Judith Berry
Julia Ryan
Rona Howard

London, 2001

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Abbreviations

AMED	Allied and Complementary Medicine Database
ARC	Arthritis Research Council
CINAHL	Cumulative Index to Nursing and Allied Health Literature
ENB	The English National Board for Nursing, Midwifery and Health Visiting
GP	General practitioner
HCA	Health care assistant
HDU	High dependency unit
MRI	Magnetic resonance imaging
MRSA	Methicillin resistant staphylococcus aureus
NHS	National Health Service
NHSE	National Health Service Executive
OT	Occupational therapist
SW	Social worker
TENS	Transcutaneous electrical nerve stimulation
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
U&E	Urea and electrolytes

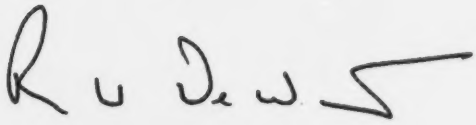
Foreword

The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the nineteenth in its successful series: ***Researching Professional Education.***

The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

The higher incidence of chronic disease and disability has contributed to a growing recognition of the importance of rehabilitation services. There is also debate about the role, contribution and professional identity of the nurse within the multiprofessional and multi-agency rehabilitation team. This important research study consisted of an ethnographic study of three sets of contrasting case studies, national workshops and extensive interviews with nurses. The results have major implications for nursing education, in particular:

- the specific skills knowledge and competency areas for pre- and post-registration education
- the importance of learning in the workplace
- the need for learning about rehabilitation to be recognised and valued by managers.



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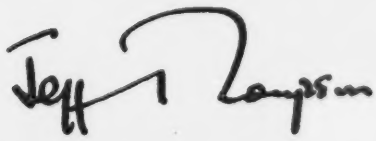

Professor Jeff Thompson
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London, 2001

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1.1 Background to the study

In recent years, the higher incidence of chronic disease and disability, greater survival rates of younger disabled people and a rising population of older people have all contributed to a growing recognition of the importance of rehabilitation services (Symington, 1994). With current anxiety over the increasing costs of health care, rehabilitation is being seen increasingly at a policy level as a mechanism for reducing unnecessary residential and long-term nursing care and, hence, expenditure (Nocon and Baldwin, 1998). There have also been concerns over the adequacies of rehabilitative service provision for disabled people (Nocon and Baldwin, 1998) especially given the renewed emphasis on quality of life and patient autonomy (Clark, 1995). Indeed, at a policy level, it has been argued that:

> *'... better evidence-based information about illnesses and disabilities and understanding of the range of services available is needed to allow individuals and their carers to take an active part in the design of care plans, and to help professionals design the best package of care.'*
> (Department of Health, 1996: 20)

This concern has been reinforced in legalisation, most notably in the *Carers (Recognition and Services) Act* (1995) which stressed that rehabilitation requirements and the impact on lay carers should be considered during need assessment. In addition, calls for a 'seamless service' have been made with the needs of service users co-ordinated and integrated throughout the health and social care sector, including primary, social and multiprofessional and multi-agency care.

1.2 The role of the nurse within the rehabilitation team

There is considerable debate within nursing research and practice over the role, contribution and professional identity of the nurse within the multiprofessional and multi-agency rehabilitation team. To cast further light on these issues, in January 1998, the English National Board for Nursing, Midwifery and Health Visiting (the Board) commissioned the University of Salford to undertake a two-year research study of the contribution of the nurse within the multiprofessional, multi-agency rehabilitation team. The project involved a collaborative team from the Health Care Practice R&D Unit and the Schools of Nursing and Health Care Professions within the Faculty of Health and Social Care. The study aimed to provide an empirical complement to the comprehensive literature and curriculum documentation review of Nolan et al. (1997a).

1.3 Research aims

The research had five aims:

- explore how the nurse identified the 'total' physical, emotional and social care needs of the client and carer
- identify the nurse's desired and actual role and contribution to meeting these needs, from the multiple perspectives of the nurse, other members of the multiprofessional team, the client and the carer
- uncover the nurse's perception of the relevance of pre- and post-registration education and other post-registration continuing professional development activities in preparation for these activities and role

- explore the ways that the nurse keeps up to date
- review the implications of the emerging findings for pre- and post-registration nurse education.

1.4 Overview of the report

The report begins with a brief overview in Chapter 2 of relevant policy and practice literature related to the role of the nurse and rehabilitation. It sets out to provide a context in which to understand the actual and desired role of the nurse within the multidisciplinary and multi-agency rehabilitation team and implications for nurse education. Chapter 3 provides an overview of the two-phase methodological approach adopted in the study. Phase 1 comprised an ethnographic study of three sets of contrasting case studies. Focus centred on the rehabilitative career of a sample of clients with one of three conditions – fractured neck of femur, rheumatoid arthritis or stroke. The client provided a window through which to examine the role and contribution of the nurse within the multiprofessional rehabilitation team. Data sources encompassed observation, interviews and record review. Phase 2 involved a set of four expert national workshops to comment on the generalisability of the findings and to explore and refine their implications for nursing education and practice. The chapter concludes with reflective comments on the strengths and weaknesses of the research study.

Chapters 4 to 12 present the findings from the three case study conditions. The reporting for each case study is broken down into three parts. The first part describes the settings used and gives a profile of the clients. The aim is to shed light on the context in which the findings on the clients' needs and the nurses' role are to be interpreted. The second part details how the nurse identified the needs of the client and carer, and how the nurse meets those needs. The third part explores areas where these needs are not met and how a change in the role of the nurse might meet them, by examining the potential or desired role of the nurse. Accordingly, Chapters 4 to 6 present the material for the rehabilitation of clients with fractured neck of femur, Chapters 7 to 9 for rheumatoid arthritis and Chapters 10 to 12 for survivors of stroke.

Chapter 13 presents key findings from the national expert workshops held in part to explore the typicality and generalisability of the findings. Chapter 14 provides a comparative perspective. It begins by examining elements of the nurse's role across the three case study areas, drawing out points of similarity and difference. It is structured around six main themes, including client and carer needs and expectations, the actual role of the nurse, issues surrounding teamworking and role variations by care settings. It concludes by drawing out implications for nursing practice through an examination of the desired role of the nurse within the rehabilitation team.

The last two chapters address nursing education issues. Chapter 15 presents findings on the relevance of pre- and post-registration education in preparing nurses for their role within rehabilitation. In particular, it examines the extent to which pre- and post-registration education prepared nurses for their role within the rehabilitation team, other ways that nurses learn and keep up to date and their and others' perceptions of learning needs. These findings together with those from the three case studies form the focus for a summary and discussion, in Chapter 16, of the implications for nursing education in relation to adult nursing.

Key points

- The current policy context for nursing education is dynamic. Key foci include lifelong learning, an educational system responsive to health care needs and working in partnership with family carers.
- The notion of rehabilitation is complex. A social and client-centred model informs this research, emphasising the maximisation of independence in the client's own environment and individual choice and control.
- Previous literature points to the variety of roles and functions of the nurse within the multiprofessional and multi-agency rehabilitation team. In particular, Nolan et al. (1997a) highlighted the maintenance of physical wellbeing, the provision of specialist care, reinforcing the input of therapists, the provision of a supportive environment and a 24-hour presence.
- The research study needs to examine:
  - how the nurse interprets rehabilitation
  - the potentiality for working in a rehabilitative manner
  - how the nurse works with other team members in different care settings
  - the client/carer experience.

This chapter provides an overview of relevant policy and practice literature related to the role of the nurse and rehabilitation. It draws on four main sources:

- policy documents relating to the practice of nursing
- recent policy literature on rehabilitation
- Nolan et al.'s (1997a) literature review on the contribution of the nurse within the multidisciplinary rehabilitation team
- a literature search undertaken to update this review.

This chapter sets out the wider context in which the actual and desired role of the nurse within the multidisciplinary and multi-agency rehabilitation team, and implications for nurse education, can be understood within primary, secondary and continuing care.

2.1 The nursing policy context

The current policy context for nursing education is dynamic. Two documents are central to discussions on the future direction of nursing education: *Making a Difference* (Department of Health, 1999a) and *Fitness for Practice* (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1999). These documents inform the key principles stated in the partnership statement from the National Health Service Executive (NHSE) and the Committee of Vice Chancellors and Principals (1999). Both documents support the current Government's objectives to develop more flexible career pathways, to increase the levels of practical skills and to have an educational system responsive to the needs of the National Health Service (NHS).

2.1.1 Lifelong learning

The Government is establishing a career ladder for nurses from cadet to nurse consultant (Department of Health, 1999a). This includes a proposal for increasing access of health care assistants (HCAs) through recognising their role, skills and knowledge. Attaining vocational qualifications would enable access to, and fast tracking through, educational

programmes leading to registration. In the rehabilitation context, this needs to be considered in conjunction with ongoing debates regarding the role, skills and knowledge of generic rehabilitation workers, and their relationship to nursing and other professional qualifications.

Fitness for Practice (UKCC, 1999) calls for the use of competency-based outcomes for pre-registration education, with subject-specific benchmarks. A suggested benefit is flexibility of access to and progression through pre-registration education. In pre-registration programmes, the development of practical skills and learning in practice placements is highlighted, with a call for higher quality and longer placements, more support for students, assessors and mentors, and rigorous, practice-based assessments. For this to happen, the learning and the teaching of practice and theory need to be more closely linked (NHS Executive/Committee of Vice Chancellors and Principals, 1999; UKCC, 2000).

There is also a significant emphasis on learning in the workplace (Department of Health, 1998a). This includes the establishment of strategies that are client-centred, and focus on the developmental needs of clinical teams across traditional professional and service boundaries.

At the ladder's pinnacle is the nurse consultant (NHS Executive, 1999). The creation of these posts aims to strengthen professional clinical leadership and provide career opportunities for experienced and expert nurses, with service/practice, research and education as core functions. Again, a key feature is the ability to work across professional and organisational boundaries. It is notable that a significant proportion of the first wave of appointments comes from the fields of rehabilitation and work with older people.

2.1.2 Changing focus of health care need

In a report commissioned by the UKCC, Warner et al. (1998) draw attention to the anticipated increase in the number of people with degenerative and chronic disease and disability. This is linked primarily to the increasing number and proportion of older people in the population, and in particular, to the projected needs of the 'oldest old'. The requirement for nurses who can develop and work in rehabilitation, intermediate care and chronic disease management services is clearly recognised. Nursing is seen as the key profession to help people manage long-term health problems, minimise dependence and maximise potential wellbeing. Furthermore, *Fitness for Practice* (UKCC, 1999) suggests that the present pre-registration branches should be reconsidered in relation to the changing profile of health care need and provision (for example, older people, community provision and non-acute care).

2.1.3 Working in partnership with carers

A continuing consumer interest and involvement in health and social care practice, together with a public demand for openness and accountability, is challenging both traditional notions of professional autonomy and the relationships between professional and informal carers (Department of Health, 1998b). Changing family structures are impacting on informal care relationships. Increasingly, the primary carers of the oldest old are themselves in late life.

Nurses need educational programmes which give them the skills and knowledge to work in collaboration and partnership with a diversity of clients, families and carers, in a wide range of settings. These will enable them to play a key role in information giving, supporting carer groups and client and carer education (for example, medication management and moving and handling techniques).

2.1.4 Changing roles

The thrust of current government health policy is dependent on effective working across professional and agency boundaries (Department of Health, 1997 and 1999b). At agency, professional and individual levels, traditional boundaries are being eroded, and the need for client-focused teamwork highlighted. These include significant role implications for community

nurses. Education has a central role to play. However, Miller et al. (1999) have recently concluded that education on teamworking does not develop the knowledge and practice base sufficiently.

2.2 Defining terms

Any investigation of the nurse's role and contribution to a multiprofessional team requires brief explanation of the meaning given to key terms.

2.2.1 Multiprofessional

The terms 'multiprofessional' and 'multidisciplinary' are often used interchangeably. In this report, a multiprofessional team refers to a group of health and/or social care professionals who come from more than one profession. Sometimes, such professionals describe themselves as coming from different disciplines as opposed to professions. In such instances, this report, following Miller et al. (1999), will describe that team as multidisciplinary. For the sake of completeness, the notion of 'interprofessional' or 'interdisciplinary' refers to the interaction between members of that group.

2.2.2 Team and teamworking

More problematic is the distinction between team and group. Miller et al. (1999: 18) draw attention to the simple definition of *'a group of people working together towards a common goal'*. This should fit easily within the context of rehabilitation services, but also belies the fact that individual members may not always *'work together'* as such, rather working independently some or most of the time. Again, this does not itself contravene the above definition. For example, individuals can work to a common goal while working independently.

The notion of *teamworking* is, however, more complex, and the subject of an enormous literature. A number of key attributes have been identified (Miller et al., 1999: 19, summarising Mandy, 1996, in the context of interdisciplinary teams), including goal directedness, understanding of each other's roles, recognition of areas of overlap, communication, flexibility and conflict resolution. The extent to which each of these different attributes is met by particular teams may differentiate successful and unsuccessful teams.

This itself is the subject of research and debate. For example, Proctor-Childs et al. (1998) reported on two case studies of effective teamwork. They drew attention to the way members worked across boundaries, communicated by telling and sharing and held a common vision. In addition, they pointed to potential benefits to clients in terms of continuity and consistency of care and the creation of a more 'holistic' picture of the client. Or, again, Tierney and Vallis (1999) examined the way that multidisciplinary teamworking operated for the care of the elderly with hip fracture. Variations in staffing levels and the composition of the team in different settings as well as styles of teamworking are important.

In this report, a looser conception of teamworking is employed. It is based on common sense, referring to the more basic use of the word 'team'. Within the field of rehabilitation, it is by no means self-evident that there is a clear understanding of the nurse's role within the context of the provision of rehabilitation, from the perspective of the nurse, the client or other team members. Furthermore, there is the question of whether and to what extent greater clarity leads to more successful teamworking and, most importantly, a more satisfying outcome and experience of care for the client. This is particularly so in a context where it is not just teamworking and what the team does that affect the client's outcome and experience, but also the resources available to provide rehabilitation.

2.2.3 Rehabilitation

Coming to an understanding of the notion of *rehabilitation* is even more complex. Indeed, while it is a common goal of both health and social care, there is little consensus on its definition at a policy or practice level (Young et al., 1999). At one end of a continuum, the term

'rehabilitation' is used in a restricted sense, referring to discrete, time-limited periods of therapy with specific goals. A simple example is the provision of physiotherapy following hip surgery with the aim of improving mobility. At the other end, rehabilitation refers to multiple inputs from health and social services, education, housing departments and benefits agencies which may be required for an individual with a disability or handicap (Robinson and Batstone, 1996). There are also significant points of difference relating to the emphases placed on restoration and achievement of an optimal level of functioning and independent living, and on the centrality of the user perspective toward making choices and exercising control over their own lives.

Robinson and Batstone (1996; cf. Sinclair and Dickinson, 1998) seek to combine both perspectives by emphasising the restorative function and purpose of rehabilitation in the context of enabling people to retain control over valued aspects of their lives. They define rehabilitation as a:

> *'... process that aims to restore personal autonomy in those aspects of daily living most relevant to service users and their families. As such, it involves the use of appropriate and available medical treatments, therapies, prosthetics, social and environmental supports, and is likely to require the collaboration of health, social services and other public agencies.'*
> (Robinson and Batstone, 1996: 23-24)

This focus on personal autonomy provides a more inclusive definition than that suggested by Nocon and Baldwin (1998). They draw a clear distinction between maintenance and rehabilitation. Maintenance is seen to refer to services and interventions to help people with chronic impairments sustain a particular level of functioning or lifestyle; rehabilitation is about *restoring* function.

A recent Department of Health policy document, the *Holderness Report* (NHS Executive, 1997: 6-7), draws on both perspectives. Rehabilitation thus encompasses:

- user and community centredness, emphasising *'the rights of individuals to make choices and control their own lives from a range of options'*
- the consideration of handicap, as well as disability, in the determination of need and planning resource allocation, *'with the focus on resumption of a role which is important to the individual, while ensuring that all underlying impairment or disability is identified, and treated and/or ameliorated'.*

Rehabilitation thus emphasises the maximisation of role fulfilment and independence in one's environment, including adaptation (personal, social and environmental) to any difference between desired and achievable roles. Accordingly, it is important to keep hold of this more social, rather than medical, and client-centred model of rehabilitation when examining the perceptions on the actual or desired role and contribution of the nurse within the rehabilitation team reported on in this study.

Finally, rehabilitation as a process comprises a number of critical constituents, including teamworking/team-care, assessment and goal setting. In this light, Young et al. (1999: 189) comment that intensive rehabilitation: *'... may include a different style of nursing, interdisciplinary teamwork, and an increasing emphasis on goal setting'.*

2.3 The role and contribution of the nurse within the rehabilitative team

While there is an emerging consensus at a policy level over the breadth and importance of rehabilitation, there remain significant differences in the use of the terminology in practice and the principles that underpin the provision of rehabilitation services. These philosophical differences have lead to wide differences in approaches to care and, within nursing, uncertainty over its role.

A variety of roles and functions have been described (Waters and Luker, 1996; Johnson, 1995; Nolan et al., 1997a), with the nurse:

- being a co-ordinator (collecting and communicating information)
- creating a supportive atmosphere and environment in which rehabilitation can take place, or maintaining patient hygiene needs, comfort and readiness for therapy
- being an 'understudy' to other therapists, for example, in enhancing skill development in dressing and undressing
- providing general or specialist nursing care over a 24-hour period.

In general, the nurse has tended to view the therapist as 'expert' and to characterise the nursing role in rehabilitation as peripheral, either as an understudy to therapists or as the non-therapeutic manager (O'Connor, 1993).

One key study in the area is that provided by Nolan et al. (1997a). In their one-year project commissioned by the Board, they aimed to provide a *'conceptual synthesis'* of key themes emerging from the literature. Searches were undertaken of nine bibliographic sources (ranging from CINAHL – Cumulative Index to Nursing and Allied Health Literature – and AMED – Allied and Complementary Medicine Database – to the Social Science Citation Index) up to 1995 with a view to identifying literature on the role of the nurse within rehabilitation, theoretical frameworks and models of rehabilitation. This was supplemented by a further search within a set of target conditions (arthritis, myocardial infarction, multiple sclerosis, spinal injury and stroke).

Their findings supported the view that nursing input was largely confined to five distinct areas (Nolan et al., 1997b):

- maintenance of the physical wellbeing of clients by providing attention to physical care needs such as skin, nutrition and hygiene
- specialist care in particular areas, such as continence and skin care
- reinforcing/carrying on the input of therapists
- provision of a supportive environment for rehabilitation to thrive in
- a 24-hour presence, often seen as portraying the nurse's unique contribution.

Such a summary inevitably hides the variety and depth of perspectives arising within individual studies. For example, in their full report (Nolan et al., 1997a: 60), five different conceptions of the potential nursing role within rehabilitation are depicted. These include the nurse as risk taker, enabler, befriender and independent facilitator (Waters, 1987), or assessor of all family members, modifier of attitudes and provider of anticipatory guidance (Hymovich and Hagopian, 1992), or care manager, researcher, advocate and educator (Hoeman, 1996). As the authors comment, many of the potential roles were both open to interpretation and require varied skills and knowledge *'beyond the ability of any one individual'* (Nolan et al., 1997a: 59).

A number of other studies have been published since this review. To extend and update Nolan et al. (1997a), a search, replicating their approach, was undertaken of CINAHL and AMED databases from 1996 to April 2000. Concepts searched included rehabilitation, nursing, nursing role and multidisciplinary working. These concepts were searched across the title, abstract, journal, institution and subject heading fields. A small number of further relevant studies were identified.

First among these is Kirkevold's (1997) study of the role of the nurse within acute stroke rehabilitation. Four therapeutic functions of the nurse were identified:

- *'interpretive'* – helping clients and their relatives to understand the ramifications of the stroke

- *'consoling'* and establishing a trusting relationship
- *'conserving'* – maintaining and meeting clients' basic needs
- *'integrative'* – helping patients to integrate their newly (re-)learned activities of daily living skills into their own daily life.

What the nurse does or may want to do cannot be viewed in isolation. Central is the need for a fuller understanding and recognition of the needs of clients, family members and other informal carers. Drawing on their condition-based reviews, Nolan et al. (1997a and 1997b) identified the continuing themes of the lack of information available to clients and their carers and a failure to involve them in the rehabilitation process. Arksey and Heaton (1998) have recently highlighted once more the plight of carers and their need for more, and earlier, information and practical help. This was reiterated in a qualitative study exploring problems faced by stroke survivors and their carers in the community (McKevitt and Woolfe, 2000). The study identified the need for more information, along with ongoing rehabilitation in the community. Similarly, in the hospital environment, Close and Procter (1999) noted the coping strategies that clients and carers used to obtain information, centred around developing relationships with nursing staff. Finally, other studies have pointed to a potential mismatch of client expectations and nurse perceptions. For example, Macduff (1998) described the client's experience of the nursing role as *'having the necessary done'* and also *'do it yourself'*. The latter is potentially highly supportive of a rehabilitative approach. But the client's expectation, as opposed to needs, might have been *'to be done to'*.

The need to explore and take account of the multiple perspectives and needs of clients and carers is a prominent and continuing theme within literature on rehabilitation and chronic illness. But not all clients or carers have received explicit coverage. Nolan and colleagues (1997a) drew attention to the limited literature on differences by race, ethnicity and culture and the impact of caring on women in society.

In addition to the user and carer needs are the models and frameworks of rehabilitation that may or could inform practice. Gibbon (1999) pointed to the limiting effect of the team conference, itself core to interprofessional collaboration and central to effective rehabilitation. Emphasis lay on disseminating decisions rather than establishing or discussing client rehabilitation goals. Waters and Easton (1999), reporting on an ethnographic case study on three clients over a four-day period, queried the feasibility of the planning and delivery of individualised care. Clients had to fit into a routine, with limited choice being offered over when to get up and where to sit. This also draws attention to the need to involve the client in the rehabilitative process, as well as the potential consequences arising from staffing shortages. Finally, Lawler et al. (1999) found that nurses within stroke care had differing interpretations of the use of goal setting, some using it explicitly and others informally in their relationships with clients. The tension between what the client would like to be able to do (a comparison to life before the stroke) and what was realistic to achieve was central (cf. Young et al., 1999).

Nolan et al. (1997a: 67) concluded their review by arguing for the need for a more holistic conceptualisation of rehabilitation, and thus the nurse's and others' roles and contributions therein. This must incorporate the needs of clients and carers as they evolve over time. Foremost is the need to address significant areas of deficit identified in the literature review (*ibid.*: 76). These gaps include:

- an emphasis on physical rather than other needs, and on the perspectives of the professional rather than the client and/or informal care
- a failure to individualise rehabilitation programmes
- insufficient attention to the provision of information, advice and education
- insufficient attention to emotional or psychological needs
- neglect of issues surrounding gender, ethnicity and culture.

Whether or not these deficits remain, and their impact on meeting the needs of the client and carer, provides an impetus to a further examination of the current role of the nurse within the multiprofessional and multi-agency rehabilitation team.

2.4 Conclusion

From the above discussion, it is evident that understanding the nurse's actual and desired role within the rehabilitation team requires three main perspectives.

- The notion of a multiprofessional team and teamworking: How is this interpreted in practice? What are the components of teamworking? What is the philosophy of care? What does teamworking feel like to the client and carer?
- The notion of rehabilitation: How is it interpreted within different care settings? What is the experience of rehabilitation from the perspective of clients and their informal carers? Are their needs met?
- The potentiality of working 'rehabilitatively', prescribed by the practice of nursing, the interrelationship of the nurse and other team members, staff numbers and mixes, and the knowledge and skills of the individual nurse.

This chapter has provided a brief overview of key issues as a backcloth for an empirical investigation of the actual and desired role and contribution of the nurse within the rehabilitation team and implications for nursing education. The next chapter outlines the way in which the study was designed and undertaken.

Key points

- The research adopted a two-phase design: an ethnographic study of three sets of contrasting case studies, with the client as the observational frame through which to look at the nurse's contribution and role, and a set of four national expert workshops.
- The three conditions of fractured neck of femur, rheumatoid arthritis and stroke were chosen for study, each with likely variation in the potential role of the nurse within the rehabilitative team.
- Settings were chosen to represent generalist and specialist rehabilitation provision, and client pathways with potential transitions between primary, secondary and continuing care.
- A total of 49 clients were recruited, with informed consent, each chosen purposively using the approach of theoretical sampling, ensuring variation in age, gender and severity of condition. They were followed for up to six months of their rehabilitative career.
- Data collection involved observation of settings, events and interactions; interviews with clients, carers and staff; think-aloud with nursing staff; staff questionnaires and record review.
- Data analysis was ongoing and based on the approach of grounded theory, identifying and attaching codes and categories and isolating more general abstracted categories and themes for generalisation.
- National expert workshops were held with four groups:
  - users, carers and carer organisations
  - nurses
  - members of the multiprofessional team
  - educationalists.

  Their focus lay on exploring the typicality of the findings and refining implications for nurse education and practice.
- The careful selection of contrasting case studies and clients, the multiple sources of data, the presentation of the data via quotations and description of situations along with the coherence of the findings with previous studies is supportive evidence of the credibility and validity of the findings.

3.1 Introduction and overview

The complexity of an evaluation of the outcomes of the contribution of the nurse within the multiprofessional, multi-agency rehabilitation team is readily apparent. As the literature review has indicated, the actual role that the nurse plays will depend on factors such as:

- the extent to which rehabilitation is provided as a team activity
- the nature of the condition or phase of care
- the setting of any intervention
- personal characteristics of team members
- the competence and fitness to practise of team members, itself based on pre- and post-registration education and other continual professional development activities.

It is essential to look beyond what nurses and other team members say is done (for example, via interview) to observing what is actually done (for example, observations of nurse-client and nurse-team member interaction) and records of that care (for example, nurse care plans, and team notes). Furthermore, client-service interactions must be observed over time, as the needs of clients and their informal carers are dynamic as their experience of the condition and service response and support increases (Long, 1995).

This complexity suggested the need for a methodological approach that would cast light on the potentially varying role of the nurse in different care settings and for different client groups. To this end, the study adopted a two-phase design. Phase 1 comprised an ethnographic study of three sets of contrasting case studies (Yin, 1995). The study design was based on an inductive, grounded theory enquiry approach, drawing on multiple methods of data collection. Building on initial observation work to familiarise the researchers with the research settings, fieldwork developed to establish insight and understanding of events and practices, grounded in the experiences and perceptions of informants, in particular, selected clients, informal carers and health care practitioners. Phase 2 comprised a series of national workshops to comment on the typicality and potential generalisability of emerging findings, and to explore and refine their implications for nursing education and practice. An overview of the study design can be seen in Figure 3.1.

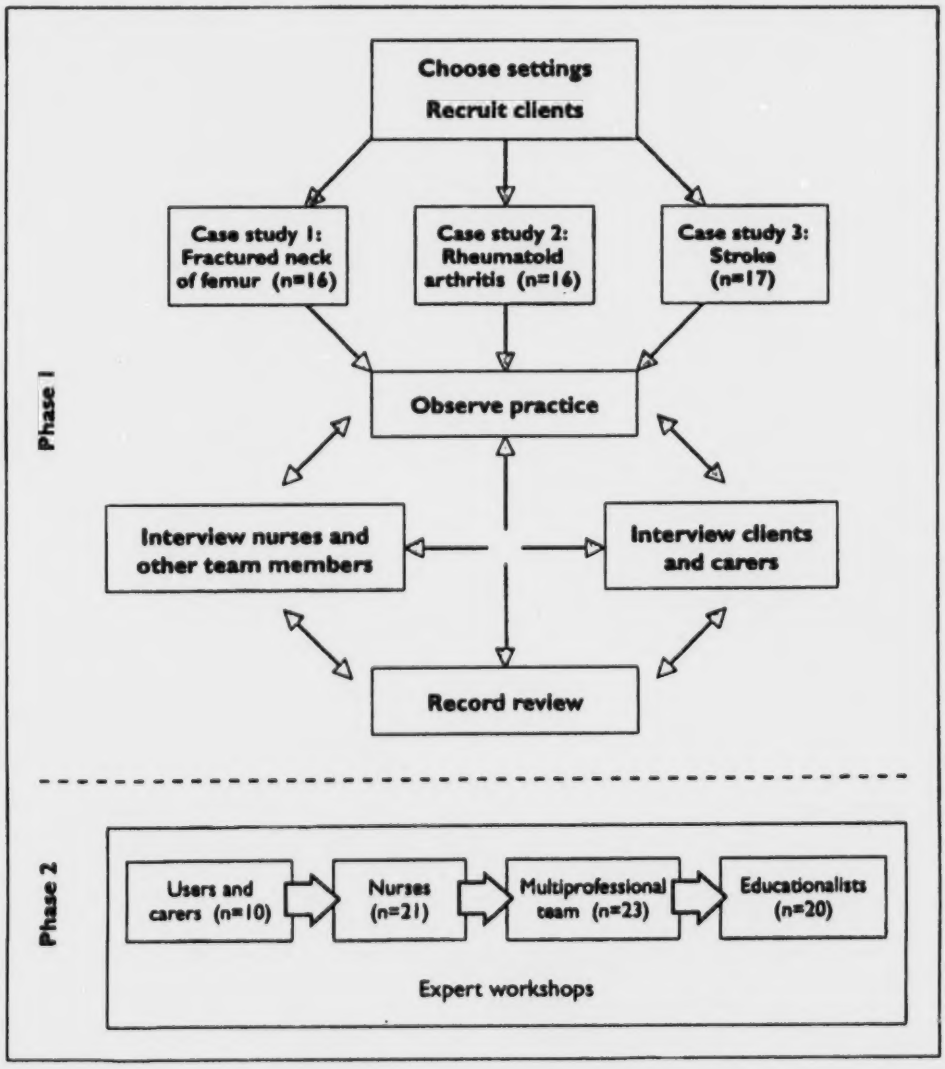

Figure 3.1: Overview of study design

3.2 Phase 1: An ethnographic case study of three conditions

This section considers the following aspects of Phase 1:

- the chosen conditions
- the chosen sites/care settings
- the selection of clients
- the selection of nurse and team members
- data collection methods
- data analysis and presentation.

3.2.1 The chosen conditions

Three sets of contrasting case study conditions were selected:

- fractured neck of femur
- rheumatoid arthritis
- stroke.

Fractured neck of femur

Fractured neck of femur is an increasing reason for admission to hospital among older people, with expectations of a doubling of crude incidence by the year 2015, reflecting the ageing of the population. A significant proportion of clients will have pre-existing co-morbid conditions, requiring not only rehabilitative care but also broader health and social care needs assessment.

Rheumatoid arthritis

Rheumatoid arthritis is a chronic disease with an unremitting course. Treatment is centred in specialist units, increasingly provided in hospitals and in the community. The nurse may or may not see her role in treatment and continuing care as contributing to the rehabilitative process. Indeed, rehabilitation may be difficult to define clearly except in relation to particular acute episodes resulting from 'flare-ups' or surgical interventions aimed at reducing pain and increasing mobility (for example, hip replacement).

Stroke

Stroke is a major cause of morbidity and mortality. While not all stroke patients are cared for in hospital, the clear research/evidence-based recommendation (Stroke Unit Trialists' Collaboration, 1998) for those who are, is to be cared for in an integrated stroke rehabilitation unit. Due to the nature of stroke care, this involves multiple therapeutic inputs, including speech therapy, physio- and occupational therapy, as well as a major role for nurses. In addition, as one of the major predictors of long-term care needs is incontinence (Mauthe et al., 1996), the nurse will have a specialist contribution to make in addressing the care needs of the client and carer in the short and longer term.

3.2.2 The chosen sites/care settings

To maximise the opportunity for variability in the nurse's role and contribution within the multiprofessional and multi-agency rehabilitation team, clients with the chosen conditions were recruited within settings where rehabilitation was expected to be delivered in different ways. Careful choice of settings was made, informed by the need to:

- cover a range of generalist and specialist provision of rehabilitation

- ensure that client pathways embraced potential transitions between primary, secondary and continuing care
- recruit clients from sites where their varied pathways to and within rehabilitation services could be identified.

The significance of the first criterion requires brief clarification. Rehabilitation in hospitals is often described as taking place in a 'generalist' or a 'specialist' environment. While what is specialist provision is not always clear, two key elements are indicative of specialist provision: the existence of a 'specialist' nurse, and/or its specialist nature being part of the stated primary focus of the service.

Implicit is a recognition that environments for rehabilitation services include some which can be categorised as 'traditional' (medically-led, physical-disability-focused and more fragmented care), and others as 'innovative'. The latter are likely to work within a more comprehensive model of rehabilitative care, addressing not only the physical aspects of disability but also psychological and social aspects, in a more integrated, team-based manner. There may also be variation in the degree of 'person-centredness' in rehabilitative service provision. This includes the extent to which clients and family are given information about the condition early on and are involved in decision making over treatment and care.

It is important to note that this approach does not imply any assumption that 'specialist' equals 'innovative' or 'person-orientated' provision. Indeed, a rehabilitative service could be correctly categorised as 'generalist, innovative and person orientated', while another, believed to represent a 'specialist' form, might in reality be better described as 'traditional' and/or 'professionally focused'.

Furthermore, there is no implicit judgement being made as to which care delivery system or environment might lead to better user outcomes. Within the research study, emphasis lies on ascertaining how different environments and methods of care delivery impact on and mould the role of the nurse within the multiprofessional rehabilitation team, and the way that this is perceived by users and carers.

All the fieldwork was conducted in one NHS Region. The region exemplifies diversity in both health care needs and approaches to the provision of rehabilitation, providing a relevant microcosm to study these issues within England. Fieldwork took place in six trusts, of which two were hospital based, one integrated, and three community. One of the community trusts had a community stroke team and another a rapid response team. A description of the multiple fieldwork sites is presented separately for each of the case studies within the relevant section of this report.

3.2.3 Selection of clients

The primary sampling unit was the client. It was their experience of rehabilitation that provided the focal observational frame through which to explore the role and contribution of the nurse within the multiprofessional and multi-agency rehabilitation team. Clients were chosen purposively. Use was made of the approach of theoretical sampling, to ensure variation in age, gender and severity of condition. While it was intended to examine any ethnic variations, there was little opportunity to explore this.

For the fractured neck of femur group, central contrasts lay around the dimension of older and frailer versus the fitter with few post-discharge needs. For the rheumatoid arthritis group, key contrasts were: newly diagnosed, younger and still working; young but severely affected; and older and more disabled. For the stroke group clients were chosen who had different expected discharge destinations, as predicted by the severity of their level of impairment, activities of daily living and current level of nursing care. Some clients were thus selected who were expected to need nursing home care, others able to be discharged to their own homes with support and others who would have few residual needs.

A total of 49 clients were recruited to the study. This comprised 16 clients who had a fractured neck of femur, a further 16 with rheumatoid arthritis and 17 clients who had had a stroke. Each client was followed up in a number of settings for up to six months. As far as possible, contact was also made with the client's primary caregiver. Direct interviews were conducted with 21 carers.

All clients were recruited from a variety of settings. For clients with a fractured neck of femur, 14 were recruited from the acute orthopaedic ward, with the remaining two being selected from an orthopaedic rehabilitation setting. For rheumatoid arthritis, clients were selected from outpatient clinics (nine) or acute medical, orthopaedic or specialist rehabilitation ward (seven) following admission for a problem related to their arthritis. For stroke, six were recruited soon after admission to an acute medical ward, seven from a rehabilitation ward and four from the client's home following discharge from hospital.

In all but a minority of cases, each client was followed up either in their own home or in other non-hospital destination (nursing home or joint nursing and residential home). Insight should thus be gained into the client's rehabilitative experience over time, captured by at least two points of verbal contact.

3.2.4 Selection of nurse and team members

The primary focus on the client within whatever setting – their own home, outpatient clinic, hospital ward or nursing home – was the determining factor in choosing which nurses and other members of the rehabilitation team to observe and/or interview. In a few instances, a number of key informants were chosen on the basis of their specialist role, for example, the elderly orthopaedic rehabilitation liaison nurse, or special knowledge in the area, whether or not they were in contact with the chosen clients.

3.2.5 Data collection methods

Multiple methods and points of data collection were used. These included:

- observation of settings (acute wards, general and specialist rehabilitation wards, clinics, visits to clients' homes, nursing homes); events (case conferences); interactions (staff-client, staff-staff)
- interviews (client, carer, staff) and think-aloud (nursing staff)
- record review (nursing, medical and other notes)
- staff questionnaire (nurses).

Observations of the provision of care

A total of 330 hours of observational work took place in a selection of typical settings in which the nurse might be involved in the provision of rehabilitation. These included outpatient clinics, acute and rehabilitation wards and accompanying a district nurse to the client's home.

Observation followed the approach of event recording. This involved recording every relevant event during a period of observation centred on the clients and their interaction with staff, or a staff member and their interactions. Interest centred particularly on the interactions of the nurse with the client and/or family carer, the nurse with other members of the rehabilitation team and specific significant events involving team members, most particularly, multiprofessional team meetings and nurse hand-overs. The aim was to understand the context in which care took place and to provide insight and direct observation of what the nurse did.

Think-aloud interviews

To follow up on the way in which the observed nurses engaged in practice, use was made of the 'think-aloud' interview technique (Jones, 1989; Fonteyn et al., 1993; Greenwood

and King, 1995). Think aloud is a research method designed to elicit information about individuals' reasoning and decision making. Individuals are asked to verbalise their thoughts during or immediately after a task.

In this study, the aim was to uncover what the nurse did, how and why, with particular focus on tasks centred on the identification and meeting of client needs and decision making. Nurses were asked to explain their actions to the client as they would normally do (concurrent think aloud). Alternatively, immediately after an observation episode, in a private setting, nurses were asked to give a retrospective account of their actions.

Interviews

Interviews were conducted with clients, family caregivers, nursing staff and other members of the multiprofessional rehabilitation team. These were tape-recorded and subsequently transcribed as appropriate. Otherwise, notes were taken and written up at the first opportunity outside the fieldwork site.

The client and carer interviews provided insight into the individual clinical, personal and social history of the informant, together with their own perceptions of the care they experienced and the contributions of the nurse and others. These were carried out in the recruitment and follow-up settings.

For the nurse and other members of the rehabilitation team, interest centred on their perception of the nurse's actual and potential contribution and role within the rehabilitation team, along with the way in which the client's and carer's needs were being met. A total of 88 interviews were conducted, 45 with qualified nursing staff and 43 with other team members, for example, physiotherapists (14), occupational therapists (OTs – 10), medical consultants (six) and social workers (SWs – five). In addition, to enhance the insight into community nursing care and rehabilitation work, two focus groups were held with district nurses from two contrasting general practitioner (GP) practices.

Record review

Care plans and other client records (team and medical notes) for all recruited clients were read regularly and selective notes taken from them. These included:

- what needs nurses had identified and how they intended to respond to those needs via direct and indirect (for example, referral) input
- what the nurse or other team member recorded that they were doing/had done for the client (to provide a contrast with what they said they were doing or were observed actually doing)
- additional information on the client's care pathway (to provide an update on what had happened to the client before the observation period)
- who was involved in the care and rehabilitation of the client
- the way in which other team members related to the nurses and perceptions of the nurse's role (for example, a physiotherapist writing in the notes that *'she has asked nurse to do ...'* or *'... to find out about the client/client's family'*)

This information was used to supplement other forms of data collection and to identify other events, people or situations for observation or interview.

No attempt was made to review the quality of nursing or other records. Indeed, it was recognised that the nursing and other client records might not provide a complete or accurate picture of client care. The records might be expected (and in fact did) record only the 'more/most significant' events.

In order to systematically cover issues relating to nurses' rehabilitation education, practice development and the skills and knowledge required, a postal questionnaire was designed and delivered to qualified nurses working in all locations where the clients had been recruited and/or observational and interview data gathered. This included both hospital and community nursing staff. A total of 240 questionnaires were delivered to the care setting and 137 returned, a response rate of 57%.

3.2.6 Data analysis and presentation

A grounded theory approach informed the data analysis of the observational, think-aloud and interview-based data. This involved attaching codes/categories to key issues as identified from the field notes and then searching for patterns, similarities and differences with a view to isolating more general and abstracted categories for generalisation. The aim of the analysis is captured in the following quotation:

> *'... to find some way or ways to tease out what we consider to be essential meaning in the raw data; to reduce and reorganise and combine so that the readers share the researcher's findings in the most economical, interesting fashion'* (Ely et al., 1991:140)

Data analysis was ongoing throughout the process of data collection. It comprised five stages:

- **Stage 1:** Reading of transcripts by at least two members of the research team independently.
- **Stage 2:** Re-reading of transcripts, introducing comments and annotations, and theoretical memos (to identify areas to follow up and to inform the further recruitment of clients and/or observation settings).
- **Stage 3:** Generation of a summary sheet, providing a précis of the interview and/or other fieldwork sources.
- **Stage 4:** Reading of a compilation of summary sheets arising from the range of data sources to identify emerging themes.
- **Stage 5:** Identification of patterns of similarity and difference, and searching for confirming and negating evidence.

A statistical package, SPSS 10 for Windows, was used to analyse the data from the structured questions within the postal questionnaire. The data from the open-ended questions were searched for common categories and themes.

In any qualitative study, it is essential that the data are interpreted within the context in which they arise. To this end, detail is provided on the settings of each case study and a brief summary of the ill-health, personal and social situation of typical, yet contrasting, clients. A short summary of all the recruited clients in each case study is presented in Chapter 4 (fractured neck of femur), Chapter 7 (rheumatoid arthritis) and Chapter 10 (stroke).

3.3 Ethical issues

Ethical approval was obtained from the appropriate Multi-Centre Research Ethics Committee and from each of the selected trust's Local Research Ethics Committees. Access to each fieldwork site was negotiated with key people in the trusts, in particular, the chief nurse and the lead clinician for each directorate involved. Access to individual clients was negotiated with the appropriate medical consultant.

Following receipt of an information leaflet, written consent was obtained from all recruited clients and family carers. Verbal permission for observation was also obtained from

the clients and health care practitioners in each setting. All informants – clients, carers and health care staff – were assured that the data would be confidential to the research team and that, in reporting on the findings, all data would be presented anonymously. Particular care has been taken to ensure the anonymity of the study sites and individuals therein in the description of the study settings within each case study. Each recruited client has been given a pseudonym. Fractured neck of femur clients have been given the pseudonym of a plant, rheumatoid arthritis clients of a gem, and stroke clients of a colour.

3.4 Phase 2: Towards generalisation – national expert workshops

Adopting a case study approach is potentially problematic in providing findings for a study with national interest. Two approaches were used to address the issue of generalisability. The first, outlined above, involved the choice of 'typical' conditions and settings and 'representative' users and then identifying contrasting settings, user characteristics and their pathways through rehabilitation services, using the approach of theoretical sampling. The second involved undertaking a series of national 'expert' workshops to explore the typicality and generalisability of the research findings and to draw out and refine the implications of the findings for nursing education and practice with four groups:

- users, carers and carers' organisations: to address the typicality and potential generalisation of the case study findings from the *perspective of users and carers*
- nurses: to explore implications *for practice*
- other members of the multiprofessional team: to explore the implications for *teamworking* and the nurse's contribution
- educationalists: to discuss the findings' potential *educational impact.*

A set of criteria was drawn up to aid selection of participants. Each invitee had to be at least one of the following:

- a representative of key stakeholder group
- knowledgeable in the area – either through practice (ill-health or work) and/or research
- from a location or organisation with credibility and/or good practice and reputation
- able to provide a perspective from outside of the study area.

For the user and carer workshop, interest lay in having both representatives of selected user organisations and users who had one of the case study conditions and their carers. Contact was made with the national (and subsequently) local branches of user and carer organisations with an interest in the case study areas (Age Concern, Arthritis Care, Citizens as Trainers, Community Health Council, Different Strokes, Help the Aged, National Carers' Association, Stroke Association and Supporting Hands). They were asked to nominate one or two people who could provide a perspective from their organisation and/or an individual who had the particular condition, or their carer. A total of 10 people took part in the workshop. These included: three carers, four people with rheumatoid arthritis, two stroke survivors and one person from an organisation for older people.

For the nurses' workshop, practitioners working in the studied condition areas and in a range of health care environments were targeted. Representation was sought from nurses working in all areas and forms of provision where rehabilitation might take place, including specialist outreach teams, district nurse and nursing homes. In addition, nurses needed to come from a range of organisational positions, from ward management to directorate manager to specialist nurse and 'basic' team member (grade E or below). Potential delegates were accessed via the RCN rehabilitation forum, recent conference proceedings in nursing and rehabilitation, recommendations from the project's Steering Group and published literature. A total of 22

people took part in the workshop. They worked in a range of areas including general rehabilitation (five), stroke care (four), community rehabilitation (three), orthopaedic rehabilitation (three), neurological rehabilitation (three), rheumatology (two) and district nursing (two).

A similar approach was adopted for the workshop for members of the multiprofessional team. Particular interest lay in ensuring representation from the main/typical team members, including social work. Four medical doctors were invited but were unable to attend. A total of 23 people took part in the workshop. Participants had backgrounds in nursing (eight), physiotherapy (five), occupational therapy (four), speech and language therapy (two), social work (two), dietetics (one) and academia (one).

Again, for the nurse educationalists' workshop, selected individuals were approached directly. They were chosen from lists of education providers offering nursing courses related to the study condition areas and rehabilitation and contact with education consortia across the English regions. A total of 20 people took part in the workshop. Participants came from a variety of backgrounds including clinical settings (community and hospital rehabilitation), managerial and academic, and educational consortia. All participants shared a strong interest in nursing education, rehabilitation and care of older people.

The workshops were run on a similar format, with brief background information being sent out beforehand. Within the workshop the participants were provided with a summary of key findings (relevant to the focus of the workshop), to be returned at the end of the event. Following a presentation by the research team (project aims, methods and relevant key findings), participants were divided into three groups, facilitated by a research team member, to examine the questions:

- Are the findings consistent with your experience, knowledge and practice?
  Are there gaps and/or areas to emphasise?
- What are the implications of the findings for the nurse within the multiprofessional, multi-agency team, and for nursing education and training?

The findings from the national expert workshops are presented in two parts: in relation to typicality (Chapter 13) and in the final discussion (Chapter 16) on the implications of the research findings for nursing education.

3.5 Strengths and weaknesses of the study

Any research report should provide the reader with reflective comments on the strengths and weaknesses of the way in which the study was performed, with a view to assisting their judgement of its validity and utility, and as a guide for further research. To this end, a brief note is provided here on some of the issues arising, as a supplement to the description of the study's methods outlined above.

3.5.1 Ethnographic approach

The strengths of an ethnographic approach lie in the richness of the data arising and an ability to situate the actions and perceptions of informants within their context. The report attempts to provide the reader with contextual detail on the clients, their informal carers and the settings of care, in which to locate and interpret the study's findings on the role of the nurse. It is, however, recognised that this has only been partially achieved. Indeed, a more intensive approach might have been valuable, focusing on fewer fieldwork settings and clients, with a view to provide in-depth insight into the actual (more longer-term) careers of the clients and their interactions with members of the multiprofessional multi-agency team. This would have enabled more intensive observation both of what team members did (with an emphasis on the nurse) and on what they said they did. A substantial reliance was made for the latter on interview data.

One of the noted weaknesses of an ethnographic approach relates to the issue of generalisability. In this study, care was taken to choose typical settings, located in one region of England with considerable diversity in terms of population and health care facilities and approaches to rehabilitation. In addition, sets of contrasting case studies and clients were selected to enhance external validity. To take this a step further, the study design included a series of four national expert workshops with participants chosen from outside of the study region. This approach provided expert confirmation of the credibility of the findings (a key criterion for the quality of a qualitative study). This may have potential in other studies.

3.5.2 The client as the focal point

Clients and part of their rehabilitative career formed the focus for the study. It was their contacts and interactions with staff that informed choice of what and who to observe and interview. Together with the set of three contrasting case studies, this in principle enabled the research team to analyse and re-analyse the data by taking a variety of 'slices' of the data. Initial analysis was centred on each client separately, exploring their interactions with nurses and other team members. For this report, the client case studies have been merged to gain comparative insight into the role and contribution of the nurse. One risk is to lose the more direct contact with the context of the client's experience and of the care setting. The reader can only be advised on the need to recall that context and take it into account.

3.5.3 Alternative foci

An alternative approach would have been to focus on nurses, their interactions with other team members and the clients, within particular care settings. This may well have provided greater insight into the nature of teamworking, the understanding of each of the others' roles and the way in which nurses work across the boundaries with other practitioners. Additionally, it would have been valuable to talk to student nurses to obtain insight into their experience of rehabilitation placements and perceptions of relevance.

One weakness of the study is the limited comparative analysis of variations by care settings. This could have been considerably strengthened by a fuller and more in-depth exploration and study of the chosen study settings before the recruitment of clients. Time and cost constraints inevitably played their part.

While every attempt was made to recruit a sample that was ethnically diverse, this did not occur. To address this omission, if time had allowed, it would have been valuable to supplement the current data by undertaking some focus group discussions with Asian and black older people. Future studies might want to think carefully about effective ways to ensure that the views of the total client group are obtained.

3.5.4 Some practical issues

Inevitably, numerous practical issues arise in such a research study, which in retrospect might have been handled differently. Examples include an observational session in an outpatient clinic where the consultant effectively told the older person that the researcher was observing their interaction (the researcher subsequently met with the client and explained more fully, seeking their consent, which was provided), to difficulties in collecting data at pre-arranged times. In the latter case, the researcher had arranged to talk to two relatives of two recruited clients (which went ahead) but was then unable to attend a case conference of a recruited client occurring at the same time.

3.6 Conclusion

The study was designed to provide in-depth insight into, and rich data on, the way in which the client, the carer, the nurse and other members of the rehabilitation team perceived the actual and desired role of the nurse. Particular strengths of the design lie in the careful

selection of contrasting case studies, clients and fieldwork sites; the use of theoretical sampling to select clients, events and times of observation; the multiple sources of data; the presentation of the data via quotations and description of situations; and the exploration of the study findings within a set of workshops with selected participants from outside the study sites and area.

Key points

- The 16 clients varied in age from 75 to 94 years. They comprised three men and 13 women.
- The cameos of their care pathways exhibit considerable variety. All but three of the clients eventually returned home. Two died and one was admitted to a nursing home.
- The care settings observed covered acute orthopaedic wards and orthopaedic and general rehabilitation wards. As part of the follow-up of clients, contact was also made with other services including district nursing teams, day hospitals, nursing homes and community physiotherapy/rehabilitation teams.

This chapter gives an overview of the range of clients included in the case study, and a brief account of the settings in which the majority of data collection took place.

4.1 The clients

The 16 clients studied varied in age between 75 and 94 years, and comprised three men and 13 women. They were all recruited as inpatients following a fracture of the neck of femur. A brief cameo of each client is presented below.

Mrs Fern, aged 93, had lived with her daughter Jane for a number of years. Mrs Fern was frail, with poor hearing, and was *'unsteady'* on her feet before the fall which led to her admission to hospital. She spent four weeks on an acute orthopaedic ward before transfer to general rehabilitation. Both Mrs Fern and her daughter said they were happy with care on the acute ward, describing the nurses as being *'on the ball'*. Mrs Fern's daughter was especially pleased when her mother was referred for rehabilitation. The ward sister of the acute ward was instrumental in Mrs Fern's transfer to the rehabilitation ward. She persuaded the rehabilitation ward to accept Mrs Fern for further therapy, in contradiction to the assessment carried out by the rehabilitation link nurse. This assessment had concluded that further progress with mobility was unlikely, making Mrs Fern an unsuitable candidate for admission to the rehabilitation ward. Mrs Fern was transferred to a general rehabilitation ward where she stayed for 18 weeks. Jane's expectations that the rehabilitation ward would provide *'intensive physio'* were not met. During her mother's stay, the physiotherapist was on sick leave for a number weeks without a replacement, and Jane did not see the nurses providing any therapy. She complained that the nurses were not *'getting my mum going'* and she did not feel involved in care. In particular she worried that staff members were trying to *'force mum into a nursing home'*. She was determined that that was not going to happen. However, the nurses on the rehabilitation ward felt that Mrs Fern was too old and frail for therapy, and that her daughter's expectations were too high. Mrs Fern was eventually discharged to her daughter's home. The district nurse visited and provided pressure-relieving equipment. Jane felt the district nurse listened to her problems. This experience, Jane said, *'made me ill, the whole thing'*.

Mrs Moss, aged 91, lived alone and before her fall and subsequent hospitalisation, managed at home independently, without any formal services. Her daughter and son-in-law lived nearby. Mrs Moss was admitted to an acute orthopaedic ward where she stayed for 18 days. The client and her daughter described the nurses on the acute ward as caring, kind and encouraging, but thought the ward *'untidy and dirty'*. Her daughter felt that she was given enough information, but had to ask. Mrs Moss was discharged back to her own home and her daughter changed her work hours to look after her. The district nurse called to treat the pressure sores that had developed while she was in hospital. The family felt reassured that the district nurse was *'only a 'phone call away'*.

Miss Rose, aged 84, lived in warden-controlled accommodation. She had no personal support from family or friends, and relied on the home care service for assistance with washing, dressing and getting in and out of bed. She also had daily meals on wheels. Miss Rose was on the acute orthopaedic ward for three weeks. She described the nurses as caring and thoughtful, but commented that *'if you don't try they aren't bothered with you'*. The ward was said to be very busy, but Miss Rose was often bored. On discharge home, Miss Rose said that she felt her mobility was getting worse, as she was having difficulty walking on the carpet and manoeuvring her walking frame.

Mr Lily, aged 78, was single and described as *'a loner'*. He was admitted to an acute orthopaedic ward after a fall. After three weeks, he was transferred to an orthopaedic rehabilitation ward. He unexpectedly died one week later from pneumonia.

Mr Rush, aged 75, was a widower with a daughter and granddaughter living locally. He was admitted to an acute orthopaedic ward. After an uneventful post-operative recovery, he made good progress and was discharged home after 15 days. Sadly, he died of a heart attack shortly afterwards.

Mrs Lavender, aged 85, had recently moved in with her daughter. Following a fall when out walking she was admitted to the orthopaedic ward, staying for three weeks, before discharge to her daughter's home. Both Mrs Lavender and her daughter were satisfied with her care in hospital, seeing nurses as helping *'get your confidence'* and *'explaining dos and don'ts'*. A point of dissatisfaction emerged after discharge when the daughter complained that members of the ward staff had not noticed a sacral pressure sore. The district nurse called to check the surgical wound, discovered the pressure sore, and started treatment lasting for several months. She also arranged for pressure relieving equipment and provided preventative advice.

Mrs Ash, aged 83, was admitted from her flat in a warden-controlled housing complex. She was found on the floor by the social service carer, after falling in the night. Mrs Ash had had limited mobility and periods of urinary incontinence since a stroke 10 years ago, and needed home care in the morning and evening. Her two sons lived locally and visited her regularly, while her daughter lived abroad. Mrs Ash was admitted to the acute orthopaedic ward, where her operation was delayed because of hypertension and anaemia. Following a slow post-operative recovery, Mrs Ash was assessed by the specialist 'elderly orthopaedic rehabilitation' liaison nurse, who consulted with others, including the client and her family. She continued to receive intensive therapy on the orthopaedic ward where there was little improvement in her mobility. Mrs Ash was subsequently discharged to a residential home.

Miss Elm, an active, independent 75 year old, fell in the garden of her home where she lived alone. She had many good friends locally. Miss Elm stayed in the acute orthopaedic ward for three weeks. She said that most of the nurses were helpful and encouraging and commented that a *'good nurse puts themselves in your point of view'*. After a home visit, she was discharged home with a referral for physiotherapy as an outpatient. She was pleasantly surprised when her first appointment came just one week after she got home. Miss Elm was also visited by the district nurse, who came *'just to see if I was coping'*.

Mrs Ivy, aged 83, lived alone in her own house and had had rheumatoid arthritis for many years. She had one daughter who lived locally and helped with 'heavy' housework and took her mother shopping. Following an uneventful post-operative recovery after her fracture she was taken on a home visit and 15 days after admission was discharged home. She was offered further rehabilitation as an outpatient, at a day hospital or at home, but she said she did not think she needed it. Three weeks after discharge her daughter said that Mrs Ivy was doing better than ever. Of her hospital stay, Mrs Ivy commented that staff on the ward *'did not want you to be reliant'*, which she thought was a good thing, and said that the nurses gave her confidence.

Mrs Cedar, aged 86, lived alone in a ground-floor flat in a sheltered housing complex, where she had lived since fracturing a hip four years ago. She had support from social service and a frozen meals service. She had visits from her family who lived locally. Mrs Cedar stayed on the acute orthopaedic ward for 10 days before she was transferred to the orthopaedic rehabilitation ward. As she had been on this ward before, both she and her family felt that they knew what to expect. Mrs Cedar's son said that when she had her first fracture, he thought that the rehabilitation ward would be more intense, but now thought that they *'paced it about right for the older ones'*. After three weeks, Mrs Cedar was discharged home with increased services and a referral to day hospital for further physiotherapy.

Mrs Heather, aged 94, lived in a ground-floor flat with her husband who was 92 years old and had 'heart problems'. Mrs Heather had not been in good health for the past three years following abdominal surgery to remove a tumour. She and her husband had support from their large family. Before her fall, Mrs Heather moved around the house, and attended to her own hygiene needs. Between them the couple managed the cooking and housework. Mrs Heather spent 10 days on the acute orthopaedic ward after her operation, where her progress was slow. The multiprofessional team was concerned about the prospects of Mrs Heather going home. The family were insistent that they would take Mrs Heather home, and so she was transferred to the orthopaedic rehabilitation ward. One of Mrs Heather's daughters said of the acute ward *'they are too quick to write them off'* and commented *'I could see Mum going downhill when she thought she wouldn't be able to go home'*. Of her stay in the orthopaedic rehabilitation ward, Mrs Heather said: *'they [the staff] just expect you to get on with it here [in the rehabilitation ward]. They give you everything you need and you just get on with it'*. She also commented that she felt the other patients were friendlier and there was *'always someone to talk to who was going through the same thing'*. After five weeks Mrs Heather went home to her husband. The family refused the offer of any services. It was arranged that the district nurse would call.

Mrs Iris, aged 89, was admitted from a residential home after falling out of bed. She was a widow with two daughters, and had been living in residential care for 18 months. Mrs Iris had mild mobility problems before the fall, needing some help to get in and out of bed and using a walking frame. She also had some cognitive problems and had a poor short-term memory. Mrs Iris made an uneventful recovery from her operation, but was making slow progress in regaining her former levels of independence. The multiprofessional team agreed to transfer Mrs Iris to a slow rehabilitation ward, from where it was hoped that she would progress sufficiently to enable her return to the residential home.

Mr Flower, a 78-year-old widower, was living in a residential home. Before his fall, Mr Flower was fully mobile and, with prompting, independent in personal care. Mr Flower was increasingly confused and irritable post-operatively, and for some days refused to take much food or drink. Eventually his physical condition started to improve, but he found it hard to remember instructions and soon became tired. It was decided that he was not suitable for the orthopaedic rehabilitation ward, and a nursing home was arranged.

Miss Jasmine, aged 92, lived alone in her own home. She had a number of close relatives. Miss Jasmine slipped on the bathroom floor in the night, and was admitted to the acute orthopaedic ward. She made an uneventful post-operative recovery, and made good progress with rehabilitation on the ward. A week after her operation she was transferred to the orthopaedic rehabilitation ward. After four weeks, and following a home visit, Miss Jasmine went home. She refused home care, but accepted a frozen meal service. After four weeks at home, Miss Jasmine reported that she was doing well, and had not yet heard from the community physiotherapy service. Miss Jasmine, who had never been in hospital before, described the whole experience as *'fascinating'*, but commented that she was often very bored as at home she was always busy. She felt that, because of her age, many of the nurses spoke to her as if *'I'm deaf or daft'*. Both Miss Jasmine, and some of her family remarked on a lack of involvement in discharge plans, and felt they had to ask for information, rather than being told automatically.

Mrs Tulip, aged 83, lived alone in her own home. She had had numerous hospital admissions, mainly for heart problems. She was supported at home by her daughter and granddaughter. Mrs Tulip was admitted to the acute orthopaedic ward, which she described as busy. The nurses *'didn't have much time for anyone'*. She made good progress and was transferred to the orthopaedic rehabilitation ward. Following a successful home visit, Mrs Tulip was discharged home.

Mrs Petal, aged 79, lived with her husband who was also in his 70s. Both were in good health. They had three children, one of whom lived locally. Mrs Petal fell off a stepladder while doing some housework. Mrs Petal spent 10 days on the acute orthopaedic ward. She described the nurses on the acute ward as being caring but very busy. Mrs Petal was then transferred to the orthopaedic rehabilitation ward. She said that staff members on the rehabilitation ward had more time to explain things and *'go through the instructions from the physio'*. Following a home visit, Mrs Petal was discharged home sooner than she had expected (although she did not see this as a problem).

C4 Acute orthopaedic ward

This was a 'Nightingale type', 30-bedded, mixed sex ward. During the data collection period, nursing care was primarily organised using a patient allocation system, with an attempt to provide consistency in allocation patterns.

Admissions with fractured neck of femur were routinely referred for physiotherapy and occupational therapy. These services were delivered by therapists who came to the ward. All members of the multiprofessional team felt that the physiotherapy and occupational therapy services were limited.

Nurses described rehabilitation in terms of regaining mobility and discharge home. It was seen primarily as the domain of the physiotherapist and the OT. There was an expectation that the majority of clients would be discharged from the acute setting. Those clients whose progress was seen as 'slow' were listed for rehabilitation. The nursing contribution was described in relation to mobility (walking people to the toilet) and discharge planning.

Multiprofessional communication appeared to be a problem, with unclear lines of verbal communication, and little if any written communication. All records were unidisciplinary. A care pathway for fractured neck of femur was in the final stages of development, and the ward manager hoped that it would be *'the way forward'*.

D2 Acute orthopaedic ward

This was a 27-bedded, mixed sex ward. At the time of data collection, staff members were organised into three teams, led by an E-grade staff nurse. Ideally, each team would have had a qualified member of staff on duty, especially on the early shift. Unfortunately the ward was understaffed. Consequently, support workers and nursing students delivered much of the hands-on care. There was also a reliance on bank staff. The pressure of competing priorities on permanent qualified staff meant that levels of direction and supervision of those delivering hands-on care was low.

A computer package was used to record nursing care plans, although written records were also kept. All admissions with fractured neck of femur were referred to a physiotherapist on admission. Only those with a problem such as a chest infection were seen pre-operatively. Routine post-operative physiotherapy was dependent on the type of surgical intervention, although it was common for the senior nurse to initiate post-operative mobility. Routine referral to the OT occurred two to three days post-operatively. Information related to clients was communicated verbally, usually via the *'nurse in charge'* on any particular shift. Some physiotherapists and OTs wrote in the ward 'communication book' and consulted the nursing notes.

Older people with fractured neck of femur were also routinely referred to a geriatrician and an 'elderly orthopaedic rehabilitation link nurse'. The latter had taken the lead in developing an integrated care pathway for fractured neck of femur, which was due to be implemented.

Typically, the nurses on this ward felt that their role in rehabilitation was limited, primarily due to time. Priority was given to the needs of the acutely ill or perioperative clients, and *'running the ward'*, which left little time for either *'doing rehab.'* or acquiring new skills and knowledge. A system of nursing staff exchanges between the acute and rehabilitation orthopaedic wards had recently commenced, and many staff members felt positive about this as a way of developing understanding and gaining skills.

This comprised a 21-bedded, mixed sex ward, set in a Victorian building. The ward aimed to use a team nursing approach, with each client having a named nurse. Teams comprised qualified nurses, HCAs and student nurses. There appeared to a high level of supervision of unqualified staff. Assessment on admission to the ward was comprehensive, including an assessment of mobility, completed by a nurse, and referred to and updated by the physiotherapist. Members of the nursing staff used a mixture of computerised care planning and written records. Other team members kept their own records. The majority of information sharing was verbal.

All clients were referred to physiotherapy and occupational therapy as a matter of routine. An integrated care pathway had been developed and piloted, but had not been fully implemented.

Nurses on this ward appeared quite clear about their actual and desired contribution to rehabilitation. While the majority felt that they *did* work rehabilitatively, there was also a desire to develop further rehabilitation skills and knowledge. Senior staff members said that sometimes management and organisational activities prevented their desired engagement in care delivery.

F1 Orthopaedic/general rehabilitation ward

This was a 25-bedded, mixed sex ward. Nursing care was organised into three teams, with named nurses. Over the past few years the ward has changed from an acute medical to 50:50 general rehabilitation and orthopaedic rehabilitation ward. Although at first nurses had to adapt and pick up skills, there was now more *'focus on nurses' learning needs'*.

Clients were routinely referred to physiotherapists and OTs. Written communication was fragmented. Uniprofessional notes were kept, although team members wrote in both nursing and medical notes. Occupational therapy was in particularly short supply with nurses undertaking washing and dressing practice.

Other settings/services

The majority of data collection took place in the above areas. As part of the research method, clients were followed up over a period of time, and contact was made with other relevant services. These included district nursing teams, day hospitals, nursing homes and community physiotherapy/rehabilitation teams.

4.3 Summary

The settings show a variety of orthopaedic services provided across the three trusts. There were differences in the approach taken in each area, with variation in the way the therapy input was structured. Following surgery and recovery on an orthopaedic ward, opportunities for transfer were either to a general rehabilitation ward or to an orthopaedic rehabilitation ward.

Key points

- Established working practices and routines guided the nursing care of clients with fractured neck of femur.
- Nurses fulfilled a key role in the initial and ongoing assessment of client needs. Other contributions included providing physical and technical care, integrating therapy and therapy carry-on, building relationships with the client and carer, co-ordinating care and discharge planning.
- A shared focus on the restoration of mobility as the prime goal of rehabilitation aided multiprofessional teamworking. As a result, rehabilitation was often equated with physiotherapy. Many nurses integrated the practice of mobility skills into everyday activities such as washing and dressing or using the toilet. This was often unrecognised or perceived as *routine*, as opposed to the *specialist* contribution of the physiotherapist.
- The age of the client often influenced judgements on the suitability of a client for access to dedicated rehabilitation settings.
- All clients were referred to the district nurses for 'routine care'. District nurses were unclear about the rehabilitative component of their role.
- There were few instances of clients and carers being actively involved in goal setting, care planning or discharge planning.

This chapter sets out to identify the nurse's contribution to the assessment and identification of client need, and the planning, delivery and evaluation of care in the context of the multiprofessional team.

5.1 Identifying the client's total care needs

This section considers the following areas:

- assessment by nurses
- assessment by other members of the multiprofessional team
- goal setting and care planning.

5.1.1 Assessment by nurses

Clients were formally assessed by a nurse through an admission process on first contact with the service. This was aided by an admission *proforma* and associated documentation, generally based on an 'Activities of Living' model. The majority of clients were admitted to an Accident and Emergency Department, before transfer to the acute orthopaedic ward. Because of the sudden and often traumatic circumstances of admission, initial assessment was limited. The client, any accompanying relative or friend, and the medical notes were the main sources of information.

The initial assessment focused on:

- checking biographical data (name, age, religion, next of kin)
- clarifying past medical history
- identifying any current medication
- observing vital signs

- observing the affected limb
- assessing pain and the efficacy of pain relief
- assessing pressure area risk (Waterlow score was the most commonly used measure).

On the basis of this first assessment, an initial care plan would be devised and referral to other members of the multiprofessional team made.

Nurses also emphasised the importance of ongoing assessment. However, while nurses continued to assess the client, it was rare for the initial assessment document to be amended. Subsequently gained information was either passed on verbally, or written in the care plan. Assessment occurred throughout the client's hospitalisation. The principal elements of ongoing assessment covered: level of mobility, experience of pain, wound care, nutrition, elimination, pressure areas, observation of the affected limb, effects of medication and mood.

For some of the above, a recognised assessment tool was used (for example, a pain thermometer or Waterlow scale). For others, a locally-devised tool was used. In many cases, the assessment and identification of any related need was based on the knowledge, experience and skill of the individual practitioner.

Interviews with nurses indicated their belief that identifying need was based on experience and the ability to identify small changes in the client's condition. Some described an intuitive element: *'You can tell when something isn't right'*.

However, client needs were for the most part seen as *'routine'* and could be anticipated:

> *'Most [fractured neck of femur clients] are routine but you need to be able to pick the problems out quickly. Especially the older ones, they go downhill quicker.'* (F-grade staff nurse, acute orthopaedic)

Nurses also pointed to the importance of assessing social circumstances and home environment. However, this was related primarily to effective discharge planning rather than the whole plan of care.

Assessment for suitability for transfer to a rehabilitation ward varied greatly among the study sites. One site had strict criteria, which had to be applied to all clients, while the others had informal, often implicit, criteria. In the latter cases, the rationale for decisions on suitability was not always clear. In one trust, assessment and recommendation for transfer to the rehabilitation ward rested primarily with the elderly orthopaedic rehabilitation liaison nurse, who worked closely with a geriatrician, and consulted with other members of the multiprofessional team. She commented that concerns about *'bed blocking'* sometimes influenced judgements regarding the suitability of individuals for transfer. In addition, older people were more likely to be labelled as a *'social problem'* and denied access to the rehabilitation ward.

This conflict in perceptions of suitability for rehabilitation was illustrated in a debate involving the liaison nurse, acute ward nurses and a physiotherapist, regarding the possible transfer of two of the case study clients.

> *'Take Mrs Iris, she has come from a nursing home, they want her back. If we can get her to her previous level of mobility, it's going to make a big difference to her quality of life. Or Mr Flower, he's got dementia, but before he was physically OK, managed to get about. Is he a candidate for rehab.? And if he's not, what do we do with him?'* (Liaison nurse)

On transfer to a rehabilitation ward, it was usual for a new assessment document to be completed to replace the one from the acute ward. Some rehabilitation nurses pointed to the lack of detail from the acute ward, particularly in respect of social circumstances. They commented that the nurses on the acute ward did not have the time to do a *'full assessment'* and it was important to *'check out'* information.

'The assessments from [the acute ward]. Well, it depends who has done them. Some are OK and some are rubbish. They don't tell you anything. I always like to do a full assessment, you know, check everything out. To be fair, they are probably too busy to do anything but the basics. We are able to get to know the patients, well we have to get to know them. I take my time when they come over here.' (Staff nurse, orthopaedic rehabilitation)

This formal admission/assessment process enabled the nurse to give information about the ward and its routine, clarify client expectations, and provide a focus for the nurse to introduce herself to carers:

> Miss Jasmine was transferred to orthopaedic rehabilitation today. The staff nurse introduced herself, shaking Miss Jasmine's hand. The staff nurse sat at Miss Jasmine's bedside, offered her a cup of tea (which she refused), apologised: *'Sorry if I ask a lot of questions you have already answered, it must get rather irritating ...'*. Throughout the interaction, the staff nurse gave information about the ward and what would happen to Miss Jasmine, as well as asking questions. The staff nurse also shared information about herself, e.g. how long she had been on the ward, and answered questions, e.g. *'Have you any brothers and sisters?'* (Fieldnotes)

'It gives me a chance to get to know them, and them to get to know me.' (Staff nurse)

'She was lovely. I felt she was really interested in me ... I don't suppose I shall remember it all, but it is good that she told me everything that is going to happen.' (Miss Jasmine)

There was a lack of clarity in the assessment criteria for access to community-based rehabilitation services. Four of the clients were offered rehabilitation as an outpatient or at a day hospital, while two were offered community physiotherapy. On discharge, all were referred to the District Nursing Service. Most frequently this was for a *'wound check'* on discharge home. But it was not unusual for members of the hospital staff to request a *'general assessment'*:

> *'General assessment ... hem ... Well, I'm not always sure what that means. I think the ward put it on to cover themselves. But if we think someone does need more rehabilitation when they go home, and it hasn't been set up ... or something happens and they need physio assessment ... Well, they could wait months before they see a physio ... and we don't have the time to do it ... So what's the point?'* (District nurse)

5.1.2 Assessment by other members of the multiprofessional team

Other members of the multiprofessional team carried out their own assessments. On the whole, assessment documentation completed by others was not consulted. The exception was medical notes, which were consulted by all. The results of ongoing assessment/monitoring were recorded in the profession's own notes. Physiotherapy and occupational therapy notes were rarely available for consultation by others. When asked why, it was generally stated that the information would be too technical and profession-specific to be of value: *'I don't think that the average nurse would understand my notes. It's better that I just tell them'* (Physiotherapist, rehabilitation ward).

The role of the nurse in constant monitoring and the identification of need was seen as valuable by other team members. In both hospital and the community this seemed to be based on the perceived accessibility and visibility of the nurse.

However, it was noted that the clients were repeatedly assessed while in hospital. Indeed, several clients commented on the number of times that they had to answer the same

questions. It seemed that these different assessments carried out by different personnel (nurses and other heath and social care professionals) at different times replicated what was already known, rather than adding to and extending knowledge about clients, their needs and responses to care.

5.1.3 Goal setting and care planning

In all hospital settings some form of standardised nursing care plan was in use, either pre-printed core plans or computerised plans, the intention being to adapt these to the individual client. The extent to which plans were individualised varied between and within care settings. For example, members of the nursing staff on an orthopaedic rehabilitation ward felt that the computerised plans were focused on acute rather than rehabilitative care, and so had significantly altered the database of problems and interventions.

There were few instances of the active involvement of clients and carers in goal setting and care planning. Even in discharge planning, it was more usual for clients and carers to be told what had been arranged (with maybe minor areas for choice), than for them to be actively involved. Client goals were described as being *'shared'* by the multiprofessional team in all settings studied. However, the mechanism by which this happened was not always clear.

While the multiprofessional team meetings and case conferences provided an opportunity to share, they often consisted of a review of activity to date and a broad discussion of long-term outcomes. Much of the collaboration and agreement on goal setting and care planning was seen to occur informally in the day-to-day interactions of practitioners. This was particularly evident on the orthopaedic rehabilitation wards, where there appeared to be a shared language and understanding.

5.2 The actual role of the nurse

Having outlined the nurse's role in identifying and assessing client needs, this section explores the actual role of the nurse in meeting these needs. The role is described thematically, drawing out major areas of activity, which many (although not all) nurses may undertake. Table 5.1 provides an overview of the actual role of the nurse from the perspectives of the client and carer, other members of the rehabilitation team and the nurse. The table should be read from left to right, moving from the client's perspective to that of other team members and then to the nurse.

Clients and carers	Multiprofessional team	Nurses
Doing the routine work Help with eating and drinking, going to the toilet, pressure area care, giving medication	Day-to-day basic care Clinical/specialist nursing skills: wound care, continence, medication, peri-operative care Work with doctor	**Physical care:** washing, dressing, eating, drinking, elimination **Technical care:** medications, pain relief, wound care, pressure areas care, peri-operative care
Do therapy when the therapists are not there	Carry on routine therapy Monitor and report back effects of therapy Need guidance from therapists Nurses don't have time to learn/incorporate carry-on role	**Therapy integration and carry-on:** mobility, washing and dressing practice
Thoughtful, kind, see you as a person Cheerful	Good relationships with clients and carers Nurses are there all the time	**Helping to cope:** being a friend, having a sense of humour
Being busy	Being busy	**Running the ward**
Information source, jargon buster	Key source of information	**Collating** and passing on information
Point of referral and access to other services and resources	Source of referral Liaise with family	**Referring** to others, liaising, co-ordinating, negotiating
Organise discharge Tell you what's happening		**Discharge planning**
Explain about things Teach you	Reinforce the information/skills taught by the therapist	**Client education:** hip precautions, breathing exercises, nutrition **Teaching carers:** hip precautions, passive exercise, moving and handling
Keeping an eye on me	Identifying problems, changes in condition and reporting them	**Identifying and preventing problems:** peri-operative, wound care, pressure areas, elimination, movement Maintaining a safe environment

Table 5.1: Perspectives on the actual role of the nurse

5.2.1 The nurse's role in 'routine' care

In general, the care and treatment of clients with fractured neck of femur was seen to be 'routine'. It was standardised either formally (though care pathways and protocols), or through accepted routine work practice. Much of what the nurse did was also described in interview or through think aloud as 'routine' care, that is, the sorts of activities that nurses were expected to do. Members of the multiprofessional team were sometimes quite vague about what nurses did:

> *'nursey things'* (OT)

> *'The things nurses do that I don't know how to do, that's their job. Their role ... [laughs] ... I don't know really ... medication ... personal care ... erm ... talking to patients I suppose.'* (Physiotherapist)

This routine care can be divided into two main categories: *physical* and *technical care*.

Physical care included activities such as assistance with washing, dressing, movement, elimination, eating and drinking. To clients and carers, these activities appeared to lack the mystique of the activities of other team members, being described as *'everyday'* and *'ordinary'*. Further, some clients and carers described an expectation that nurses would carry out these activities *for* the client, rather than enable self-care and independence.

Many nurses said that they integrated rehabilitation principles into these physical care activities, but this was not apparent for all nurses. A range of behaviour was observed:

> The staff nurse and student nurse were walking with Miss Jasmine to the bathroom ... The staff nurse was observed using minimal touch, using verbal prompts coaching and encouraging.
>
> Mrs Ivy asks to go the toilet. The staff nurse calls for a student nurse to *'bring a chair'*. No assessment of Mrs Ivy's ability/desire to walk. She is wheeled to and from the toilet.

Technical care describes the clinical aspects of the nurse's role. It includes wound care, management of continence, administration of drugs and peri-operative care. Nurses commonly reported these activities as part of their specialist contribution to the rehabilitation team. Members of the medical staff recognised technical care as being part of the nurse's role, but rarely mentioned physical care. This contrasted with clients and carers, who saw the nurse as the person who *'helped'* with personal care, rarely mentioning technical care.

Other members of the multiprofessional team, and clients and carers, commonly made reference to the nurse as being *'the person who worked with the doctor'*. The nurse was perceived as being a source of medical information.

5.2.2 The nurse's role in rehabilitation therapy

Rehabilitation was almost synonymous with mobilisation. When asked what rehabilitation was, most professional staff members discussed mobility, and the impact of reduced mobility on functional ability. Clients and carers also identified the rehabilitation process as related to regaining mobility. It is not surprising therefore that clients and carers described rehabilitation as *'something that the physiotherapist does'*.

In many ways nurses and other team members had a clear idea of the nurse's contribution to rehabilitation therapy, based on either written protocols, or unwritten understanding of the routine care. Their role was identified primarily in the context of providing motivation and encouragement and enabling mobility.

> *'The main thing is to get them going as quickly as possible. The older ones. Their confidence goes. You have to give them plenty of encouragement, otherwise some of them will just sit there.'* (Staff nurse, acute orthopaedic)
>
> *'... they worry about falling again. I try to give advice, about getting round the house, getting up and down the stairs.'* (District Nurse)

Traditionally the role of the nurse had been one of carrying on and monitoring the rehabilitative treatment initiated by others. Typical comments were:

> *'We continue therapy when the therapist isn't here.'* (Staff nurse)
>
> *'We do a bit of physio at weekends, walking patients up and down.'* (Staff nurse)

However, it was commonly asserted that it was difficult to find the time to *'do therapy'* at weekends. Nurses on the rehabilitation wards in particular felt criticism from other professionals. A senior staff nurse on an orthopaedic rehabilitation ward highlighted this:

'It's unfair to expect nurses to do everything, do everybody's job as well as their own, and then complain that someone hasn't had walking practice for instance.'

This perception was shared by some of the other professions.

'The nurses will dress someone, rather than dressing practice. They don't have the time that I have. They have to get everyone up and dressed. I can spend an hour with someone if I want. The nurses can't do that. They say, "Here are your things, I'll be back in five minutes".' (OT)

Other members of the multiprofessional team saw the carry-on role as being under their guidance. A major element of the role was the identification and reporting of changes in the client's mental or physical state, and the implications of change for rehabilitation therapy.

Some nurses developed the carry-on role. A senior orthopaedic nurse on an acute ward commented:

'We used to wait for the physio to start mobilising. Not any more. Now the senior nurse makes the decision and puts it into action.'

When asked on what basis the nurse made this decision, the initial answer was *'experience'*, but then:

'We're a lot more knowledgeable then we used to be. Putting together the integrated care pathway, talking to other people, reading research, has been useful, so it's clear what we can and can't do.' (Senior orthopaedic nurse)

Nurses working in rehabilitation settings were more likely than those in acute settings to view their nursing activities as rehabilitative. For example, in one episode of observation, a staff nurse in an acute orthopaedic ward took Miss Jasmine to the lavatory. She was quite obviously coaching the client throughout this process, giving advice, feedback and encouragement. However, in the retrospective think aloud that followed, the staff nurse said only that she had helped Miss Jasmine to stand and had walked with her, failing to draw out the complex array of skills she had been using.

In contrast, the staff nurse who helped Mrs Cedar to get dressed was able, using think aloud, to identify what she was doing and why.

'I know Mrs Cedar's had a fractured hip in the past, so she has been through all this. So I started by finding out how she has been managing to get dressed at home, and also what she can remember from OT yesterday. She gets upset, so you have take your time, that's why I sat on the edge of the bed, and joked that is was time I had a few minutes sit down. I tried to make it like a conversation ... She knows how to use the "helping hand" to put her stockings on. So I asked her to tell me what she was going to do, then I watched her, telling her how well was doing. It was only at the end that she needed a bit of help – and that was because I could tell from her face that she was uncomfortable.' (Staff nurse, orthopaedic rehabilitation ward)

Many nurses were thus integrating the practice of mobility skills with other activities, such as going to the lavatory, getting into a chair to go to the X-ray department, or getting into bed. However, clients and carers saw this as *routine* elements of the nurse's role, in contrast to the specialised, discrete episodes of treatment by a physiotherapist. As a consequence, the actual or potential rehabilitative therapeutic component of these actions was not always visible.

5.2.3 The nurse's role in emotional care

It is more difficult to isolate the separate elements of emotional care. The language used by participants to describe what was happening was less precise. The delivery of emotional

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care was often hidden, and sometimes was not clearly acknowledged by the nurse. It was common to describe the physical aspects of care, but to either fail to recognise or describe the emotional or psychological care, or to minimise the skills demonstrated.

When asked what they valued about the role of the nurse, clients and carers discussed emotional care and support more often than they did physical or technical care. Positive experiences had nurses described as kind, thoughtful, cheerful, and encouraging. Miss Jasmine described how *'When you do a little bit more, the nurses are as pleased as you are'*.

Many clients said that the nurses helped to give them confidence and encouragement. In the observation of practice, in both hospital and community settings, the majority of nurses provided verbal support and encouragement. Clients and carers commented on the nurse's role in helping them adjust to life changes. Mrs Heather said that she sometimes felt depressed and worried that she might not be able manage at home as she did before, but said her *'named nurse'* helped: *'When I'm a bit low, I like to talk to [staff nurse], she puts me right.'*

Nurses spoke about *'helping people to cope'* and being there as a source of support for clients and carers.

> *'He's a private man, you know. He's got used to us now and he looks forward to us going. His wife certainly looks forward to us going, and we have a good old chin-wag ... It helps her to cope, knowing there's someone to talk to.'* (District nurse)

Nurses used almost self-deprecating language when describing what they do. Emotional care was rarely included in written records, but was passed on verbally, either in report or to individual practitioners, for example, staff nurse to physiotherapist:

> *'I'm not sure how Mrs X will do this morning. She was upset and crying in the night, [staff nurse] is with her, having a chat ... maybe you'd better leave her 'til later.'* (D-grade staff nurse, orthopaedic rehabilitation ward)

While the client's emotional state was not usually recorded, changes in mood were. But as one nurse put it: *'I don't have the mental health skills. I can tell that something is wrong, but I'm not sure what'* (E-grade staff nurse).

Members of the multiprofessional team clearly saw the nurse as having a major role in delivering emotional care and support to clients and carers. While in hospital this was sometimes described as a function of the 24-hour-a-day contact, some also suggested that nurses' skills were more developed in this field, and that nurses had a more holistic view of the client. Nurses were seen as *'putting them [clients] in the right frame of mind for therapy'* (Physiotherapist).

5.2.4 Nurse's role as communicator

The nurse's role as communicator was complex and closely linked to management and organisational functions. While there were differences between the various settings, there were some similarities. The nurse was often described as the main point of contact and co-ordination for members of the multiprofessional team, clients and carers. This seemed to be based on two premises, first that the nurse (in hospital) is there for 24 hours a day, and second that the nurse has a holistic view of the client and carer.

The nurse's role had elements of:

- information gathering, synthesis and dissemination
- co-ordination of a wide range of activities
- supervision of unqualified staff
- liaison and negotiation.

Hospital nurses often described this multifaceted activity as *'running the ward'*. The time-consuming nature of this activity was not always recognised by other team members. Indeed no interviews with clients, carers and other members of the multiprofessional team in hospital settings specifically drew attention to the role of the nurse in running the ward. They rather commented that the nurses were *'always busy'*.

Observational data in the hospital settings showed the nurse being a main agent for disseminating a wide range of information from diverse sources. This information was usually not simply relayed, but subject to analysis, synthesis, and decision making. For example, in a period of 90 minutes, a staff nurse on an orthopaedic rehabilitation ward had, for one client, communicated with 12 people: two physiotherapists, one OT, two doctors, one pharmacist, the ward clerk, one SW, a student nurse and two HCAs, as well as the client. Through these discussions, the progress of the client and efficacy of interventions was established, problems identified and new plans made.

From the clients' and carers' points of view, the main aspects of the communicator role related to information giving, education and discharge planning. Not only were nurses generally described as the main source of information, they were seen to be able to make things understandable.

In both hospital and community settings, nurses were also identified by clients and carers as being a key resource for access to other services. Many referrals by nurses were routine and part of accepted protocols or work practices. In non-routine situations, the therapist was seen as a source of expert advice. Tensions were apparent when this advice failed to add to the existing nursing action. For example, a staff nurse declared that it was *'pointless referring to the dietitian'*, as the advice offered was *'what we are already doing – "eat more and offer supplements"'*.

The teaching role of the nurse was widely recognised in interview data and was seen in observation. Client and carer teaching were observed in relation to hip precautions, breathing exercises, nutrition and pressure relief. Other team members described the nurse's role as being to reinforce the information given or skills taught by the therapist.

Differing perspectives were evident among professional staff members regarding the organisation of discharge. Nurses, OTs and SWs all laid claim to being the primary profession involved in discharge planning. On the whole, clients and carers indicated that discharge planning was the responsibility of the nurse. This may be because, as observation indicated, the nurse was often the person who spoke directly to the family.

5.2.5 The nurse preventing problems and minimising risk

While the phrase 'risk assessment' was not used, nurses in all settings recognised and carried out some aspect of this function, in particular the identification and prevention of problems.

Clients and carers indicated that the nurse had a role in monitoring their condition and identifying potential problems: *'The nurse keeps an eye on you'* (Mrs Iris) and *'They make sure everything is going right'* (Mrs Heather).

Some team members valued the nursing contribution to the risk assessment process. Nurses were described as having a *'more holistic view'*. For example, a period of observation included a discussion between the ward sister, staff nurse and physiotherapist concerning the plan for handling and moving one of the case study clients. Afterwards the physiotherapist said:

> *'I don't always think enough about things like pressure sore risk, and I didn't know how depressed Mrs Iris was feeling. All these things are important. I always ask the nurses ... the information you know ... means that my risk assessment is better, and then ... Well, the whole package of care will be better.'*

Particular areas of concern in identifying and minimising risk were: peri-operative care, wound care, pressure area care, elimination, movement, safety on discharge and at home.

Finally, in all care settings, it was common for nurses to discuss the tension between maximising the independence of clients and the potential for harm. This was often expressed as fear of litigation and the response of relatives if, for instance, a client should fall.

5.3 Summary

The care of clients was often based on written protocols or well-established working practices. Role boundaries, including shared role activities, appeared to be recognised by all team members. This apparent congruence was aided by a shared focus on the restoration of mobility as the prime goal of rehabilitation therapy.

The actual role of the nurse covered a broad range of activities, ranging from providing physical and technical care to reinforcing therapy, onward referral, emotional support, communication and client and carer education, as well as the organisational responsibilities of ward management and discharge plans. Many of these elements were seen as *routine*, with the majority of clients following a clear care pathway. Primary and shared focus lay on restoration of mobility. In general, the nurse reinforced therapists' inputs, with some nurses explicitly integrating rehabilitation principles and techniques into their care of clients.

FRACTURED NECK OF FEMUR: UNMET NEED AND THE DESIRED ROLE OF THE NURSE

Key points

- Clients and carers identified a number of unmet or partially-met needs, including a lack of full and accurate information, a lack of involvement in decision making and a lack of social and emotional support. Other areas of concern were pain control, nutrition and pressure area care.
- A need for more therapy was noted in both hospital and community settings.
- Clients identified lack of time as a key reason for nurses or other multiprofessional team members being unable to meet all of their needs.
- The majority of nurses were clear as to how and why they would like their role in rehabilitation to develop. To a large degree these perceptions were consistent with those of the clients, carers and other team members. Nurses desired more time to talk with and support clients and carers.
- All members of the multiprofessional team recognised the potential for nurses to develop rehabilitation knowledge and skills. More specialised clinical skills were identified, in both physical care and rehabilitation.
- The desired role identified a number of gaps in the delivery of care. Some were due to staffing numbers across the multiprofessional team or service structures. The desired role included more time for the nurse to have a more integrated rehabilitation role.

The previous chapter explored areas where the nurse was meeting the needs of clients and carers and aspects of her actual role. This chapter takes the analysis a stage further, examining the desired role of the nurse through the expectations and needs of clients and carers, and the perspectives of the nurse and other members of the multiprofessional team.

6.1 Areas of unmet need

Clients' unmet or partially-met health care needs may be an indicator of the potential role of the nurse in the context of the multiprofessional team. From the client and carer perspective, two main areas of concern were identified (Figure 6.1):

- relationships between the client, carer and the multiprofessional team
- the experience of care.

Figure 6.1: Client and carer unmet needs after fractured neck of femur

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6.1.1 Relationships between the client, carer and the multiprofessional team

Three main areas of need were identified as being unmet or only partially met:

- need for information
- involvement in decision making
- social and emotional support.

The *need for information* was of great concern to clients and carers and a cause of considerable frustration. Particular information needs were identified, including treatment, progression, possible outcomes and discharge plans. Some clients and carers commented that they were not given appropriate, relevant information when needed, and that they often had to ask rather than be given information without prompting. *'Having to ask'* was described as difficult because nurses and others were seen as being very busy. There was a fear of being perceived as *'demanding'*. Clients and carers related a common experience of being *'passed on'* from one person to another without getting any answers. Their statements were supported by observations of practice. On the whole, nurses were described as being *'down to earth'* in their information giving. They were often relied upon to decipher the meaning of information from other sources, particularly from doctors.

Another perceived difficulty was a lack of consistency in the information and advice given.

> *'I don't know if I'm coming or going. One tells you this, another tells you that. Why can't it be set out, all the same? Then everybody would know what's going on.'* (Mrs Petal's son)

Clients and carers commented on *a lack of involvement in decision making*. This was highlighted in observations of discharge planning. Family members were not routinely involved in such decisions, rather they were informed of the decisions made by the team. The nurse usually gave the information to them. In other areas of care and treatment, while there was an apparent commitment to the involvement of clients and carers, there was little evidence of this happening consistently.

Clients and carers clearly stated that they valued the *emotional care and support* given by nurses, but more was required. The impact of skilled support was observed in practice. However, clients and carers commented that nurses were *'too busy'* to sit and talk. Mrs Tulip, who had been in hospital a number of times, commented that:

> *'The nurses don't have time for anyone any more. They're always running 'round. Sometimes I sit here all day. I want to go home. I just want to cry. If only I could talk to somebody ...'*

6.1.2 The experience of care

Partially met or unmet needs related to aspects of clinical care, staff attitudes to older people and lack of appropriate services or therapy contributions. Three aspects of clinical care came in for particular comment: pain management, pressure area care and nutrition.

It was common for clients in the hospital setting to say that they felt that they had to ask for pain relief. But they did not like to ask, as the nurses were always busy. A telling observation was made on an acute care ward, when a client asked a staff nurse when the next *'tablet round'* was. The staff nurse replied giving a time later in the afternoon and carried on with recording clinical observations. The client's implied need was not taken on board.

Six of the 16 clients (38%) developed pressure sores. This was a cause for distress, particularly among carers, who often related pressure sore development to poor nursing care.

Similarly some clients and carers expressed concern about nutritional status, and the provision of adequate and appropriate food and drink.

Both clients and carers commented on the impact of age on the attitudes of staff members and service provision. Miss Jasmine, aged 92, was not alone in commenting that: *'they [the ward staff] treat me as if I'm deaf or daft ... [Nurses] don't seem to appreciate that the elderly take longer to get over the shock.'* Mrs Fern's daughter was insistent that her mother's treatment (or lack of it) was a result of ageist attitudes. Staff members' comments were:

> *'The rehab. ward? I think it's too intensive for the elderly. They just block up the beds there.'* (Staff nurse, acute orthopaedic)
>
> *'The elderly don't respond as well as younger people.'* (Physiotherapist)

Clients and carers commented on a perceived lack of appropriate levels of service in hospital and in the community. They reported a need for more *'rehabilitation'* or *'therapy'*. However, the commonly-expressed view from health care professionals was that the scarce resource of specialist rehabilitation should be focused on younger people: *'It's hard to get proper rehab. services for the over 70s'* (District nurse).

A general issue was the need for social interaction and mental stimulation. Many of the case study group described being bored while in hospital. For example, Miss Jasmine sat by her bed talking to two other clients, discussing the ward. Comments included: *'The day goes on forever'*, *'I thought we'd be doing more'* and *'All there is is [the] telly blasting away'*. Mrs Ivy complained, *'It's all waiting ... waiting for the op. ... waiting for the doctor ... waiting for the physio ... waiting for dinner'*. Clients also commented on reduced social activity after discharge, particularly if this entailed going out of their home: *'I don't really feel very confident about going out. There's nowhere for me to go'* (Mrs Tulip).

6.1.3 Summary

While the above has drawn attention to observed areas of unmet needs, it must be recognised that experience of unmet need was in many cases a matter of degree rather than an absolute. Clients and carers valued very highly those nurses who went a long way to meet their needs. For example, there was the nurse who took time to talk and share a joke; the one who did not seem to mind how many times he had to explain something; the one who noticed you were in pain. One client, awake in the night, said:

> *'I was worried that I might not get home, I felt lonely, missing him [her husband], and my leg was hurting. The night nurse was lovely, she made us a cup of tea and brought a couple of pills, she didn't just go away, she sat here for ages, just talking. I didn't sleep, but I felt better.'* (Mrs Petal)

For clients and carers, expressions of unmet need were often given in relation to 'good' experiences. They were questioning why this did not happen all the time.

6.2 Desired role of the nurse

A wide variety of perspectives on the potential or desired role of the nurse were obtained. These are illustrated in Table 6.1, indicating areas of similarity and difference in the views of nurses, other team members and clients and carers.

Desired role of the nurse from the perspectives of the:		Expectations/needs of clients and carers
Nurse	**Multiprofessional team**	
Developing rehabilitation nursing: • knowledge and skills to 'carry on'/'*do rehab.*' • moving and handling • gait • role in the community, nursing homes	Increased knowledge of and skills in rehabilitation Moving and handling skills Need more time/staff to share skills and knowledge with nurses	More time with therapist More rehabilitation therapy in hospital and at home Better access to services, aids, adaptations on discharge and at home
More time to listen and provide emotional support	Providing more emotional and psychological support	Emotional support To be seen as an individual Someone to talk to
Developing clinical practice: • evidence/research base • continence • wound care • tissue viability • older people • preventing falls		Pain management Prevention of pressure sores Good nutrition
Increased involvement of carers	Spend more time with the family	Being kept up to date
Health promotion Teaching clients and carers	Greater involvement in health promotion/ education	More education More information
Social activities		More stimulation to overcome boredom and isolation
Better teamwork To feel valued	More shared goal setting and care planning	Effective communication Consistent information and advice from team members Better staffing levels
Recognition of the time/skills needed to fulfil the communicator/ co-ordinator role		

Table 6.1: Multiple perspectives on the desired role of the nurse

When asked about their desired role in rehabilitation, the first thing most nurses said was that they wanted (more) time to *'do rehab.'*, and to talk to clients and carers. From the nurse's perspective, the development of rehabilitation nursing would involve the acquisition of a clear knowledge base to support skill development.

> *'I want to know why something has to be done a particular way – not just how to do it.'* (Staff nurse, acute orthopaedic ward)

Other members of the multiprofessional team held a similar view. It was recognised that nurses could be more involved in assessment and the provision of rehabilitation therapy. Time was seen as a major factor impacting on this development. Not only would nurses need time to develop the skills and knowledge, but:

'We [therapists] need more time, more staff to share what we do. I don't know enough about what nurses do. We never have time to learn from each other, it's just doing.' (Physiotherapist)

The need for reciprocity of such learning is notable.

Nurses also saw the need to develop clinical practice, broadly through the vehicle of evidence-based practice. Areas of particular concern were identified, some of which do not match entirely those identified by clients and carers. For example, the nurses drew attention to extra therapy activities they wanted to do, whereas the clients spoke of the need for more time with therapists themselves.

The role of the nurse in emotional care was seen as one area needing development. A number of nurses mentioned 'counselling skills'. Two nurses, in separate trusts, commented that a palliative care course had developed skills that they felt were applicable to rehabilitation nursing. One said:

'I'm not afraid to ask questions now. I used to be worried about the reaction I might get. If someone gets upset, I know what to do.' (F-grade nurse, orthopaedic rehabilitation)

Nurses described difficulties in developing both social and therapeutic communication. In hospital and community settings, they felt that they did not have enough time to *'get to know people'* and *'listen to their problems'*. A staff nurse from the rehabilitation ward commented that she:

'... came to rehab. because it was like proper nursing, getting to know people and their families. It's changing, we don't have the time any more.' (Staff nurse)

This was echoed in comments from clients and carers.

'There are times when you don't see anyone to talk to.' (Mrs Ivy's daughter)

'Nobody has the time to listen to an old woman like me. It's not their [the nurses] fault. They're only young girls. They don't understand.' (Miss Jasmine)

Nurses were also seen by all groups as being well placed to develop a greater involvement in providing information, health promotion and education for clients and carers.

Nurses recognised that clients were often bored and lacked social stimulation. Any strategies to combat this fell by the wayside in times of high workload: *'We used to do activities on the ward, but that's dwindled off'* (Staff nurse, rehabilitation ward).

In the community, nurses recognised a lack of opportunities for social interaction for many clients.

'I think that sometimes they are frightened to go out, in case they fall, or at night they probably feel vulnerable. There aren't many places for them to go, unless you've got transport it's difficult to get out and about.' (District nurse)

The recognition of carers' needs was identified, but again time was seen as the major obstacle:

'It's an important part of the job. Supporting the family. There's a lot of talk about carer stress but we don't have time to do anything about it. We have to do so many visits, that's all that matters.' (District nurse)

Finally, there was an expressed desire for better teamwork, and an understanding of each other's role. This was even in teams that professed that they had effective teamwork already. There was a common identification of the need to have a better understanding of other parts of

the service – through acute, hospital and community health and social services – and to develop roles that bridged apparent divisions. One trust had started 'job swaps' between staff nurses on acute orthopaedic and orthopaedic rehabilitation wards. The staff members involved said that they felt that they and the service had benefited from the experience.

However, it is interesting to note that nurses were sometimes seen as passive and rarely initiating action. An orthopaedic consultant said he wanted nurses to *'be more proactive'*. Other team members commented on a perceived lack of confidence among nurses.

> *'Orthopaedics is medically dominated. Nurses don't challenge. Surgeons are just interested in fixing the fracture and then home. If you don't fit this picture you're a problem. Nurses and the multidisciplinary team [just] take this on [board].'* (Senior nurse)

6.3 Summary

The majority of nurses was clear as to how and why they would like their role in rehabilitation to develop. To a large degree these perceptions were consistent with those of the clients, carers and other team members. The main reasons that such roles had not developed were time and competing organisational priorities. For hospital and community nurses, considerable time and energy was spent in doing the communicator/co-ordinator role. This role and its associated skills appeared to be under-recognised and/or undervalued by other team members. Consequently, nurses expressed a range of desires including reducing the proportion of time spent on these activities, relevant preparation through education and training, and greater recognition from colleagues for this contribution to the team.

The desired role identified a number of gaps in the delivery of care. Some were due to staffing numbers across the multiprofessional team or service structures. More time to talk to clients was identified and for the nurse to have a more integrated rehabilitative role. However, a need for more specialised clinical skills was also identified, in both physical care and rehabilitation.

Key points

- The 16 clients varied in age from 30 to 83 years, with a median of 72 years. They comprised four men and 12 women.
- The cameos of their care pathways exhibit considerable variety. A few clients were in hospital to receive treatment for pressure sores; others had been admitted for a period of assessment and rehabilitation following acute flare-ups and/or interventions such as a hip replacement. The majority were living at home.
- The care settings covered outpatient clinics run by specialist practitioners, a rehabilitation unit, acute wards and a nursing home. Data were also obtained from visits to clients in their own homes.

This chapter provides an outline of the clients with rheumatoid arthritis (RA) in this case study and the settings in which they experienced rehabilitation and nursing care. Its aim is to situate the findings within the context from which they were drawn.

7.1 The clients

The 16 clients varied in age from 30 to 83, with a median of 72 years. They comprised four men and 12 women. For those recruited as an inpatient, reasons for admission to hospital included severe pressure sores, high pain levels and a generalised flare-up. A brief cameo of each client is presented below.

Mrs Ruby, aged 77, had had RA for four years. She lived with her husband who had heart problems (palpitations). Other family members living nearby were in work. She received treatment from the consultant and sometimes saw the specialist rheumatology nurse at outpatients. Her GP also had some involvement with pain management and medication. However, to their concern, Mrs Ruby had received inconsistent advice from the consultant and her GP over pain management and medication. She was recently referred to the OT.

Mrs Diamond, aged 78, had had RA for over 10 years. She attended appointments at the hospital every six months or so and had been seen by the specialist rheumatology nurse who provided her with a diet sheet. Her main carer was her daughter, who worked and visited four times a week. She felt that her mother *'needs more stimulation'* but Mrs Diamond did not want to go to a day centre. As she was housebound, a carer came each day from social services and she had a careline emergency button. A district nurse came weekly to dress a leg ulcer.

Mrs Emerald, an 85-year-old widow, had had severe RA for two years and was very deaf. A home help came in during the week. Her sister, aged 81, stayed with her at weekends, but found caring a strain. Mrs Emerald confided that she *'would rather go into a nursing home than make her sister live with her'* as she knew her sister loved her own home. Treatment had been given via her GP, although neither Mrs Emerald nor her sister felt that he had been very helpful. Her care had recently been taken over by the rheumatology consultant, who described her as *'a battler'*. Mrs Emerald was admitted to hospital for 'convalescence' (slow-stream rehabilitation). She and the SW are currently looking at a number of nursing homes.

Mrs Sapphire, aged 58, had had RA for three years. She lived with her husband, who was the main carer, with physical and social support from her family. The OT had provided adaptations and education on joint protection. She saw the rheumatologist every six months, but commented that he never volunteered any information (*'if I don't ask, ... then he don't tell me nothing'*). She had never seen the specialist nurse and complained of the lack of support from her GP for anything but painkillers.

Mrs Gem, aged 83, had had RA for eight years. She lived with her husband who was also in his 80s. She received consultations and treatments from the rheumatology consultant with a small level of involvement from her own GP. She had been seen by the OT who provided joint protection education and implements to help in the house. She had seen the rheumatology nurse at clinic: *'there was a young lady. She asked all the questions the doctor would normally ask'*. Mrs Gem felt that the health services are ageist, commenting that *'once they see your date of birth, they don't want to know'*. She doubted the value of the hospital consultations and treatments and wanted her own GP to be more involved in her care.

Mrs Jewel, aged 73, had had RA for eight years. She lived with her husband who was the sole carer and *'does everything for me ... He doesn't need any help ... But if anything happened to ... [him], I'd be stuck'*. She attended a day centre where she enjoyed *'mixing with other people'*. She had four-monthly hospital visits (rheumatology consultant or specialist nurse) and knew she could ring the hospital if she had a flare-up. She had a very good relationship with her consultant. She had had one hip replacement. The district nurse came to dress leg ulcers.

Mr Stone, aged 67, had severe RA, and lived with his wife. He was recently admitted to hospital with a sacral pressure sore after sleeping in his chair for several months. His wife was also sleeping in a chair and was worn out. Their house was to be pulled down, and the district nurse was hopeful that they would get a transfer to a house for disabled people, or sheltered housing. He needed help with everything. Social services carers came every day. The Social Services Community care plan aimed to maintain him in his own home by monitoring nutrition and medication.

Mr Opal, aged 60, had had RA for 30 years. He was admitted to an acute medical ward with a serious pressure sore, then transferred onto a rehabilitation ward. He had not received any specialist input from a rheumatologist before his hospital admission. To his distress, the consultant suggested a move into a nursing home. Although Mr Opal reluctantly agreed to go into a home, he felt that greater attention from the physiotherapist, while on the acute ward, could have prevented his rapid deterioration. Mr Opal hoped that his mobility would improve enough for him to go home at some point. He received physiotherapy in the nursing home, and input from the specialist tissue viability nurse.

Mrs Garnet, who was in her 30s, was hospitalised for three weeks and diagnosed with RA and fibromyalgia. Her husband has given up his job to care for her, as she did not want a *'stranger'* looking after her. She used a walking frame at home, but felt isolated as she could not go out. She was not able to look after her two school-age children as she used to. The family provided emotional support, but Mrs Garnet felt guilty and a burden. The community SW tried to offer support. The district nurse provided a pressure care assessment. The specialist rheumatology nurse was not involved.

Miss Pearl, aged 76, had had RA for 17 years. She lived alone, was very independent, and looked after her aunt. She was satisfied with her care, receiving hospital check-ups (*'MOTs'*) with either the consultant or the specialist nurse, and joint injections and physiotherapy three or four times a year. She kept up her physiotherapy exercises at home. She was very active and independent, and wanted to maintain her autonomy: *'I can manage to do everything I need'* and *'when the time comes then I'll ask'*; *'I don't think it is necessary for me to tell them everything as long as I can manage'*.

Mrs Jet, aged 48, had had RA for five years. She lived in a bungalow but had difficulties with cleaning and housework due to painful feet and hands. She was considering surgery. She saw the rheumatology consultant six-monthly, and had been referred to the OT and podiatrist. Her family was a source of great support. She was still able to work as her employers were helpful in allowing her to move to a department where she could sit down.

Mrs Jade, aged 80, had had RA for about 40 years. She was admitted to an acute orthopaedic ward after falling. She had been discharged from slow-stream rehabilitation one week earlier. She was originally admitted with social needs and for rehabilitation. While having a place at a residential home, she decided to return to her own home. Her RA was managed by the GP and consultant rheumatologist. She also received the input of the geriatrician and opthalomologist. Her principal carer is her elderly daughter, with her grownup grandchildren helping.

Mr Ambor, aged 74, had had RA for 20 years. He lived with his wife and could only walk a few steps with a zimmer. Following numerous joint operations he had recently had a hip replacement. He was under the care of a consultant and received community physiotherapy as well as visits from the district nurse to provide pressure sore care to his heel and sacrum. He was considering a nursing home as his wife was struggling as a full-time carer. He regretted that he does not have an electric wheelchair to go outside as his wife found it difficult to manoeuvre the manual wheelchair (*'she gets puffed out'*). He was on the waiting list for an electric wheelchair.

Mr Crystal, aged 45, was married with children. He has had RA for three years and was unable to work. He could walk about 50 metres, but had problems with stairs. He was experiencing high levels of pain. He was recently referred to the rheumatology consultant, having been managed by his GP before this. Following referral he was admitted to the rheumatolgy rehabilitation ward. The nurses did a full assessment, provided information and education, and onward referral to the OT and SW. He was amazed at the support he received here in comparison to that provided by his GP.

Mrs Topaz, aged 44, had had RA for 18 years. Her care was managed by her GP, but she had been seeing the consultant for two years. She had good support from her family (without which she *'would have had a breakdown'*), although she wished that they understood more about her disease. She was recently admitted to hospital with generalised inflammation in all joints. She was referred to the OT and received information and education from the nursing staff. She was very impressed by the care that she experienced in hospital, but felt frustrated she had not had this input before. Since discharge she remained unable to work and received pain relief with injections from the practice nurse. She hoped that the OT would visit her at home to see if there were any adaptations she could make to her house.

Miss Coral was a 70-year-old woman with RA, whose main carer was her sister who lived two doors away. Miss Coral was in hospital following a hip replacement, having had previous joint operations. She was very keen to get home, feeling that she was losing control of her affairs and daily life, especially as she could not get out of a chair without help. She talked with the SW after the operation (he was *'very supportive'*) and he was trying to arrange a larger home-care package. She had recently been on a home visit. It was planned that social carers would come every morning and night.

7.2 The settings

Some details on the range of settings of the fieldwork for the rheumatoid arthritis case study are provided below. This information is intended to provide insight into the context surrounding the experiences of the clients and the actions and comments of the nurse and other members of the rehabilitation team.

A1 Acute medical ward

This comprised a 29-bedded medical ward with modern décor, with three bays and three side rooms. Each bay had a nursing station and there was also a central nursing station at the entrance to the ward. There was a client day room with a television. The ward admitted male and female cardiac and other 'medical' clients.

The nursing care of clients was led by the E-grade 'named nurse' whose name was shown above clients' beds. Each named nurse took a team of clients (all located within one bay) while auxiliary, support worker staff and D-grade nurses moved between the client teams. Nursing care plans usually comprised a combination of pre-written and individually-written plans.

Three consultants were linked to the ward. The physiotherapist covered three other additional wards while occupational therapy staff members were linked to consultants. Other members of the multiprofessional team (for example, speech and language therapist, dietitian) could be contacted at the central department for the hospital. Two consultants held multiprofessional team meetings, while the third doubted their value, as all team members could rarely attend the meeting. Case conferences could be set up if clients' relatives wanted this or if the plan of care was very complex. Notes were not shared among members of the

health care team. Physiotherapy and occupational therapy staff members tended to write in medical notes as well as their own where they felt this to be necessary. SWs wrote in the nursing notes.

A2 Acute medical ward

This ward comprised 21 beds and focused on rheumatology and general medical cases. Occupational therapy and physiotherapy cover were provided by the directorate service. Clients were under the care of one of the three consultants. The ward had a standard Nightingale layout, split into male and female ends. The named nurses were at E grade and staff members worked in teams. A system of shared client notes had recently been introduced. All staff members, nursing, medical and therapy, wrote in the same notes. The charge nurse had a keen interest in research but found it hard to find time to implement changes to practice.

A5 Rehabilitation unit

This 15-bedded unit was purpose-built to cater for clients with more complex rehabilitation needs. It admitted clients with a variety of conditions, but particularly strokes. Clients stayed an average of two to three months.

Treatment co-ordinators – the physiotherapist, OT or F-grade nurse – assessed clients around the hospital for suitability for admission to the unit, with potential clients for admission being discussed weekly. Multiprofessional team hand-overs occurred once a week. The remainder of the time, communication between nurses and others was informal and via client notes. Each professional wrote their own notes and these were kept in a single folder. Notices were posted above the bed, for example, in relation to moving and handling and washing and dressing, to aid specific communications on client care. Monthly client case conferences involved the whole team, client and family. Despite these, communication was an area acknowledged as requiring development.

The unit's physical environment was conducive to rehabilitation. It had a large lounge, dining room area, therapy rooms with equipment, adapted bathrooms, toilets and showers, individual bedrooms and four-bedded bays and patio area. However, some clients found a lack of buzzers problematic in some areas. This meant that some clients were not safe if left alone in rooms.

Trust A: Outpatient rheumatology service

This was managed by a rheumatology nurse-practitioner, with two full-time consultants. She ran five nurse-led rheumatology clinics a week, operated a telephone help-line and visited rheumatology clients around the hospital. She did no home visits although this was felt desirable. Clinics tended to be pressured due to long waiting lists.

Trust D: Outpatient rheumatology service

One full-time consultant led this service along with a part-time nurse, who had a special interest in and knowledge of rheumatoid arthritis. The clinic was described as nurse-led. The nurse saw clients for follow-up and review and to assess client pain, medication, lifestyle and understanding of the disease. The nurse did home visits one half-day a week. It was hoped that a telephone help-line would be provided in the future. The consultant felt there was a need for another full-time consultant and three or four specialist nurses.

F3 Rheumatology rehabilitation ward

The ward comprised 15 beds. Clients of all ages were admitted, with men and women having separate rooms. It was open seven days a week, but many of the clients went home at weekends, as there was no physiotherapy, occupational therapy or hydrotherapy over that time. A multiprofessional team approach was evident on the ward. Meetings of the whole team took

place once a week if possible. There was a partitioned teaching area off to one side of the day room. Although a planned education programme for staff (and also client education sessions) had been devised, this was failing due to staffing problems.

Trust F: Outpatient clinic

The clinic was led by two specialist nurse-practitioners for rheumatology. Clients were either referred by their GP or self-referred. It provided a multiprofessional clinic for one consultant, with access to occupational therapy, physiotherapy and pharmacy. The specialist nurse's role included running a telephone help-line, following up clients in the clinic once seen by the consultant, providing education, referrals, team advisor, liaising with GPs and practice nurse, and doing joint injections. Due to time pressures, neither counselling nor home visits were undertaken, though these were recognised to be part of the role.

Nursing home

This was a very large, modern, private joint nursing and residential home. It was part of a large chain of homes. It had 62 resident beds, and a total staff complement of 65, of whom 13 were qualified. Therapy input was obtained upon referral to local trusts.

7.3 Summary

The brief client cameos show that rehabilitation is provided from a variety of sources. This included GP and consultant care, and input from nurses and other members from the multiprofessional team. Care was provided in outpatient, hospital and home settings. Family support was invaluable to many clients, especially as a multiprofessional approach to care was only a recent occurrence in many cases.

Key points

- Observational data pointed to the significance of the language used by nurses in their assessment of the needs of clients and carers. Centred on listening, key components were asking, assessing, acting, explaining and giving information, reinforcing and reassuring.
- The emphasis on assessing needs, either in outpatients or on admission to hospital, centred on activities of daily living, developing a relationship with the client, carer and family, and deciding who to refer on to in order to make rehabilitation happen.
- The nurse's contribution to meeting client and carer needs in rehabilitation ranged from assessment, providing care (physical, emotional and social) to helping with the therapy, being a resource for the team and being busy (running the ward). In the hospital setting, some nurses felt that their responsibility for 'running the ward' detracted from direct client contact.
- Nurses took a lead in co-ordinating the client's care to ensure that physical, emotional, social and medical needs were met. This involved ensuring correct referrals, preventing problems, providing direct care, building a relationship with clients and their families, client education, discharge planning, encouraging the client and providing an information resource for the multiprofessional team.
- The therapist saw the nurse's role in rehabilitation as centred on preparing the client for therapy, providing feedback and advice and carrying on therapy exercises.
- Some nurses found it hard to define their own role in rehabilitation, especially in a context of staff shortages (therapy and nursing), wider work pressures and a perception of the nurse as *'jack of all trades'*. In addition, there was evidence of the traditional rivalry between nursing, therapy and medical professions.

This chapter looks at the contribution of the nurse to meeting the rehabilitation needs of the clients. It has two parts. The first part explores how the nurse identifies the needs of the client and carer, and in particular, how the nurse assesses the needs of the client. The second part examines how the nurse meets these needs.

8.1 Assessing the needs of clients and carers

This first part of the chapter looks at:

- the language of assessment and client reviews
- assessing the needs in the hospital setting.

8.1.1 The language of assessment and client reviews

Observational work in a range of outpatient settings and on hospital visits drew attention to the significance of the language used by the nurse in identifying the needs of clients and carers. The needs arising were either for the nurse to address or, more commonly, for the team or particular team members, thus suggesting a critical role for the nurse as co-ordinator of care.

Key components of the nurse-client dialogue, based on the nurse *listening* to the client, were as follows.

- *Asking* the client what has happened since the last visit, particularly getting the client to recap on progress made and/or problems faced.

- *Assessing* using relevant and appropriate clinical means. These included testing hand and grip strength as well as asking the client to assess their own level of pain.
- *Acting* on the information gleaned and/or provided. This took many different forms. In one instance, the nurse went and got the consultant to see the client. In another, the nurse went to discuss the client with the consultant. In response to a query from the client about what she tells the consultant, she replied:

> *'In a nutshell what is wrong ... what you seem to want ... He [the consultant] asks what I think should be done ... he sees if he agrees.'*
> (Specialist nurse)

Other examples involved making a referral (to community occupational therapy or physiotherapy), ordering X-rays, liaising (with others on the treatment plan or with the Citizens Advice Bureau disability officer) or making a re-appointment.

- *Explaining* or *giving information* or *answering* queries. Illustrations are extensive. For example, clients asked *'Are the drugs a cause of my headaches?'*; *'What will happen if I miss a tablet?'* In some instances, information sheets, Arthritis Research Council (ARC) leaflets and a contact telephone number were given out. In others, the client was advised not to *'overdo it as you can do a lot of damage to your joints'*. Or, when queried about why she was in so much pain, the nurse explained that rheumatoid arthritis could be more active at this time. Again, to a client who felt tired all the time, the nurse explained the benefit of regular rests and *'not to worry about it [taking them]'*. At other times, giving information was extended into *demonstrating* how to use, in this instance, a TENS (transcutaneous electrical nerve stimulation) machine.
- *Reinforcing* treatment. This comprised both *telling* and *explaining*. The following extract provides an illustration, along with the follow-up action the specialist nurse undertook for the client, the consultant and the client's GP.

> The nurse says, *'You must take cyclosporin in two doses or it does not work'*. The client does not know this. The nurse says she will also write to the GP to tell him as well, and writes the new medication in the client (self) monitoring book (how many tablets and when to take them). Subsequently, following a query from the observer, the nurse commented that the consultant's letter to the GP did not make it clear that the dose should be twice daily. She would remind the consultant to make it clearer.

- *Reassuring* the client. Responding to one client, the nurse pointed out that the medication should not make him feel sick, but that if it did then it would have to be changed to one that he could tolerate. Or again, the nurse provided a contact telephone number (*'to ring any time if they experienced problems'*). And, in the words of the carer of a client: *'I knew you would come. You really helped last time ... Sometimes a talk does more than a box of medicines'*.

Such descriptive language is highly significant and was common across observed settings. It is perhaps unsurprising given the nature of the expected role of the nurse in leading a clinic or working independently or in acting in a complementary role and relationship with the doctor. In itself, it does not indicate that the nurse was assessing or addressing the total needs of the client. It rather provides an indication of the process used to gain the necessary information and insight to do so.

8.1.2 Assessing the needs in the hospital setting

Within the similarity noted by nurses on meeting client and carer needs, particular emphases were placed on the importance of assessing needs at outpatients or on admission to hospital with a primary focus on activities of daily living, developing a relationship with the client and family and deciding on referrals.

On the first of these, a sister commented:

'We do assess the needs at admission which I know all nurses do when patients are admitted ... [but] you actually tend to look further than perhaps you would do if they came in, you know, if they were in cardiac failure or whatever. You actually look at their needs, just basic things like can they manage at home? Can they cut food up? Can they wash? Can they do basic things like, you know, like wiping their bottom? And from that assessment you then go on and say, yes, they do need to be seen by occupational therapy ... So we identify a need and then they identify the appropriate things that you know are required.'

Not only does this suggest a focus on assessing their physical and social needs, it also points to the role of the nurse in referring and ensuring these needs are addressed. The same sister also raised the issue of meeting clients' emotional needs:

'If they have altered body image which they do have ... they have a lot of psychology needs ... their lifestyle has to change because of the condition ... you know to have somebody there who would be able to see them while they're in hospital would be superb, giving them coping strategies and actually taking them away from their family.'

Moving beyond the client to the family was also of significance.

'It's a relationship that you build up. You don't just look after the patient, you look after the whole family because you get a feel for them as well ...' (Sister)

'Maybe they're a young mother, a young father, and you know, you've got young children who still want to be picked up and want to have cuddles. You know, you've got to give them things, like, get your children to stand on a chair, and then pick them up from that way and you're not putting as much strain on your joints.' (Specialist nurse)

This provides a further illustration of an attempt to address not just the physical needs of the client, but also their and their family's/carer's social and emotional needs.

Across all data sources, the need and importance of explaining and providing information was noted, along with liaising with others to check that the client is seen by the team. In this regard, the nurse was:

'... overseeing the whole process ... overseeing that everything that should be being done for that patient is being done ... making sure that it is working ... monitor[ing] the effects of what is being done.' (E-grade nurse)

Within the hospital context, *'allocating key workers so that everyone has got someone to take a personal interest in them'* provides an important approach. This helps to create an environment conducive to rehabilitation. Commenting on her role and its impact on the client's needs, a nurse pointed out:

'My role is to encourage the rehabilitation of patients who have come in with a flare of RA. "You need some motivation, some rehab."' (Staff nurse)

The aim of the assessment and the provision of rehabilitation is to foster independence:

'Patients are no longer encouraged to be dependent. They're encouraged to focus on what they can do rather than what they can't do.' (Sister)

8.1.3 Summary

This section has considered how the needs of the client and carer are elicited, assessed and perceived by the nurse. In some instances, the process has illuminated details of some of the needs themselves. The analysis now turns to explore perceptions of the actual role of the nurse in meeting the identified needs.

8.2 Actual role of the nurse

A wide variety of nurse contributions to meeting client and carer needs were identified and are summarised in the categories below (Table 8.1). The table should be read from left to right, moving from the client's perspective, through that of other team members to that of the nurse, noting elaborations and omissions.

Clients and carers	Multiprofessional team	Nurses
Assessing how you are	Assessment and referral Continuous assessment and ongoing monitoring of the client	Assessing Identifying needs Ongoing assessment and monitoring
Caring • physical • emotional • explaining how you are • being a 'good nurse' – friendly, caring, patient	Providing care • physical • emotional • social	Caring • physical • emotional • social • preventing complications
Advising/providing information	Source of medical and nursing knowledge for the team Source of information for client Providing client education	Providing information Problem solving with client Providing client education Explaining and empowering
Working with the doctor • specialist nurse • other nurses	Clinic leader and co-ordinator Doers of care Referring	Resource for the team Referring, overseeing, co-ordinating or making rehabilitation happen Advocating
Helping with therapy Promoting independence	Preparing client for therapy Liaising with team Carrying on from the therapists Providing feedback/advice to the team if therapy doing harm	Helping client Encouraging rehabilitation
Sorting out discharge		Discharge planning and continuity of care
Busy nurses	Nurses work to different priorities Nurses are there with clients	Running the ward

Table 8.1: Perspectives of the actual role of the nurse

8.2.1 Similarities in perspective

It is instructive to note the similarity of perspectives evident in a number of areas, for example, the nurse's role in assessment and ongoing monitoring of the client. This role extends across to providing information to the team on how the client is responding to therapy or whether rehabilitation is *'causing any physical harm'*. This may occur, for example, if transferring the client is *'bad'* for pressure area care (OT). The assessment role is also important at ward rounds, team hand-overs and client notes/care plans.

Caring provides another example where unanimity was evident. For Mr Stone and Mr Opal, who were being treated for pressure sores, physical help was provided in *'helping me out of bed'* or *'taking me to the bathroom'* or lifting. The nurse pointed to her anticipation of the client's activities of living needs, *'so they don't have to ask you'* as well as doing clinical nursing (for example, taking blood, monitoring vital signs, giving injection, continence, wound management, pressure area care).

A particular forte of nurses perceived by other team members was their skill in addressing emotional and social needs: *'interpersonal skills'* (Physiotherapist), *'communication'* (OT, Physiotherapist), being *'diplomatic'*, *'approachable'*, *'a good listener'* and *'able to use interpersonal skills to raise compliance with treatment'* (Consultant), and *'creating a family-like atmosphere'* (OT). Most importantly, the nurse developed a relationship over time with the client and the family.

> *'It's a relationship that you build up. You don't just look after the patient, you look after the whole family ... They actually become more or less friends ... in a way.'* (Ward sister)

To this unanimous picture, the nurses added their role in preventing complications, particularly in pressure area care. This was also commonly perceived as a key role of the district nurse in a community context.

8.2.2 Areas of difference in emphasis and detail

A number of areas have greater detail and potentially different emphases. One example is the nurse as *'advising/providing information'*. For the client, the nurse was a critical source of information.

> *'[If] anything new comes up ... I just ask, because that is what they are here for.'* (Miss Pearl)

While the nurse as *'patient educator'* was well-recognised by other team members and the nurses themselves, the nurse was a source of information and knowledge for the team, in monitoring how the client is doing and the effects of therapy. This was important both in hospital and in the community. The SW, in particular, valued the advice provided by the nurse and in liaising/referring on clients for support.

However, it is interesting to note a contrasting comment from one staff nurse:

> *'I feel very uncomfortable with patient education, but I'm probably the only one here that does. Because we have a pharmacist who gives drug education ... We have hundreds of leaflets from ARC, that couldn't explain the disease process better and yet, as nurses, one of our roles is patient education, to sit and talk to patients about their disease process. And I feel uncomfortable about that because of my lack of knowledge, when there are all these other aids that could do it better. I think, talking about patient education, I think you've got to focus in on what patients need from us. It's no good us doing what somebody else is doing.'* (Staff nurse)

Another area of contrast is the role of the nurse specifically in *'helping with therapy'*. For many of the clients, there was a clear differentiation between the role of the nurse and that of the therapist in relation to their rehabilitation. For example,

> *'I need professional help from a physiotherapist in the home. I mean, they [the nurses] help me like when they get me out of bed in the morning, you know, in to the chair, and my legs will bear my weight, but that's all.'* (Mr Opal)

> *'The nurses did their job and they never infringed on the physiotherapist's job.'* (Mr Opal)

But this client continued:

> *'It was because they were so busy – there's no time for a chat or helping people with their physio.'* (Mr Opal)

Both a need and a potential valued role for the nurse are evident here.

8.2.3 The therapist perspective

From the therapists' perspectives, the nurse's role centres on preparing the client for therapy, providing feedback and advice on how the therapy may be interacting with other physical care needs, and most importantly as *'carrying on'* the therapy exercises. The rehabilitation side comes from physiotherapists and OTs.

> *'The nurses see their role as "doing" – not mobility and transfer, that's the rehabilitation side of it.'* (Physiotherapist)

Both the SW and OT echoed this. Furthermore, it was perceived as matching the client's perspective:

> *'I think they [patients] see nurses as givers of care, you know, and they expect to be, like, done to and things like that.'* (Physiotherapist)

The contrast in roles was clear. *'We actually give them physical treatments'*, commented the physiotherapist. Even more clearly, the OT stated:

> *'There is a big overlap of what we do and what nurses do. But we look at it in a different way. Yes, washing and dressing nurses will go and do … but [when I] go and do washing and dressing, I'm assessing for different needs that we can address as OTs … As a nurse they go in there to get people washed and dressed. I go in there to assess them and to try and increase their own way of doing it … to increase independence.'* (OT)

However, another OT suggested that at least part of the difference might be a result of a lack of time.

> *'It would be nice if nurses could spend time with the patient, helping them to get dressed but giving them time to do it themselves. But I know nurses are stuck for time, so they tend to dress them and wash them …'* (OT)

And she continued:

> *'But a nurse wouldn't be able to sit there for an hour and help and observe someone getting washed and dressed … What they might do is sit someone at the sink and then leave them and then come back half an hour later and see how far they've got.'*

Again:

> *'For speed they wheel them to the toilet and they wheel they back again, whereas if it's a rehab. ward they really should be seeing how far they'll walk.'* (OT)

8.2.4 Carrying on

Carrying-on from the therapists may not happen (as much as it might be desired by all parties). This might be due to the nurse's lack of time (all clients pointed to how busy the nurse was), lack of confidence in their own skills and different priorities (in the words of one nurse, *'to run the ward'*). In addition, there was a lack of consistency due to lack of time. For example, occupational therapy staff failed to write things down in the client's care plan.

In the specialist rheumatology ward, observed on three separate days, the multifaceted nature of the nurse's role is evident (see Table 8.2). As the nurses commented:

> *'Rehabilitation is just taking people to hydrotherapy and giving them physio, there isn't time for anything else. We spend all our time chasing up things today which we sorted yesterday and getting the doctors to do what they are supposed to.'*
>
> *'Rehabilitation here is focused around the physio and OT. Nurses come way down the list. We're just here to sort out all the complicated things like medication, communicating, everything towards discharge.'* (Sister)

The nurse's wider role as ward manager is germane here.

Category	Examples
Listening	About effect of illness on client's life – empathising; *'no one has spoken to me like this before'*
Explaining and preparing	What to expect – *'you will be fully assessed by all members of the MDT, the physio, the OT, the podiatrist, the doctors'* *'You can ask anything you like…'*
Educating	*'Continue with exercises, but don't overdo activity on your legs'*; side effects of drug; benefits of medication (e.g. on sleep pattern); suggesting more regular use of pain killers. *'I've never really discussed any pain relief with anyone. No one takes it seriously, they just back off and make you feel like you are whinging'* Staff nurse queries if ever been in touch with a self-help group … explained its value (information about new treatments, new ideas, education, mutual support); help in applying the TENS machine
Offering choice	*'Do you want a shower or a wash in your room?'*
Asking	About possible link-up with practice nurse (to assist in pain control)
Reassuring	*'Doctor will be around this morning'* – after a painful night
Referring	To physio; to welfare rights officer to help with re-employment and OT; and passing on information (to doctor, pharmacist)
Providing care	Apply wound dressing; checking blood pressure, pulse and temperature; assessing/querying pain control
Doing the drugs round	Giving medication (given workload, drug round done one hour late; problem for clients such as Mr. Crystal who is meant to have the drug – stomach protector – one hour before food) Assessing need (painkillers) and ensuring have a therapeutic dose (Client: *'I'll take one off you'* Nurse: *'Have two, have the therapeutic dose'*)
Managing the ward	Sorting out bed status – client once mobilised could go onto elderly rehabilitation ward; do an admission; chasing up MRI (magnetic resonance imaging) scan, dressings; staff for tomorrow, swapping shifts and ordering bank nurses according to skill mix needs; locating medical notes
Busy	Staff nurse asked auxiliary to cover the office, *'otherwise, I'll never get near a patient again. I can't do it all week. It's crazy'* *'I'll get near a patient in a minute … I'm doing the ward clerk's job and everyone else's'* (annoyed but laughing)
Teamwork	Discussion between staff nurse and pharmacist over whether the doctor has done the weekend scripts; one missed; will pharmacist sort this out. MDT not functioning very well – trying to re-arrange a day which suits everyone; seen little of OT or SW, or doctors. Doctor keeps changing the time of the ward round and SW cannot come *'Communication has really suffered. Not seeing people face to face. Although things [are] written in notes, we are not always getting time to read it … Podiatry services are a bit thin … Patients can be going home before they are seen.'* Mix up over client's hydrotherapy – *'… the physio did not confer with us at all. They are supposed to speak to us about who is going to hydro and check it's alright … They usually tell us who they want to take, what treatments they will be having and we check if they're meant to go'.*

Table 8.2: The nurse's role: observations of a staff nurse working on a rheumatology rehabilitation ward

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8.2.5 Encouraging rehabilitation

Other informants perceived the nurse as providing an important role in promoting independence and encouraging rehabilitation. As a client commented,

> *'They're beginning to lay down the law now because I am getting better – they're not molly-coddling me ... They're beginning to say do things for myself ... washing me face and me arm. Before, they used to do it.'* (Mr Opal)

The nurse saw a key part of her role as creating an environment conducive to rehabilitation. *'Being caring'*, *'being firm'*, *'having patience'*, *'providing motivation'* and *'encouraging rehabilitation'* were the phrases used by G-grade nurses in the staff interviews. *'Continuing the work of others'* was mentioned, in particular, working with the client to achieve goals within the domains of other health care professions.

8.2.6 The 'total' role of the nurse within the team

Within the clinic setting, the rheumatology nurse specialist was seen by clients as working with or beside the doctor: *'She asked all the questions that the doctor would normally ask ... I think she is helping him'* (Mrs Ruby).

Team members saw her as leader (in the nurse-led clinic) and co-ordinator following protocols (as a specialist nurse). She also played a key role in referring clients on to other team members, social services and accessing other aides and equipment. The ward sister pointed to her role in *'facilitating the rehabilitation process'*; *'overseeing the whole process'*, and *'checking that everything that should be done is being done'*.

8.2.7 Personal characteristics of the nurse

Clients repeatedly placed considerable importance on the personal characteristics of the nurse. For example:

> *'He really, really cared about his patients ... he'd sit and talk to you, he was great.'* (Mrs Garnet)

> *'She's got a lovely disposition, lovely ways. She makes you feel better when she's here.'* (Mrs Diamond)

> *'They make you feel at ease, nothing's too much trouble ... you feel you are wanted ... it takes all the fear away.'* (Mr Crystal)

These should be considered with the comments from team members about *'the nurse having more contact with patients'* (Physiotherapist) or being able to *'give them more time'* (Consultant). In addition, within the community context, a number of clients drew attention to the valued practical and emotional support that they had received from SWs (Mrs Garnet and Miss Coral).

8.2.8 Role definition confusions

While the categories in Table 8.1 indicate a clarity of perspective over the breadth and content of the role of the nurse within the multiprofessional, multi-agency rehabilitation team, this was by no means unanimous. Interlaced were comments such as:

> *'It is harder to define [the nurse's role within rehabilitation] than other professional occupations.'*

> *'[And a concern] not to take on too much of others' role.'*

Rather than there being a *'uniqueness'*, it was described in terms of:

> *'Being in the hub. You know, we are liaising with everybody, like OTs, physios, medical staff ... and we are at the centre ... They each have their individual role, but ... they always come back to us.'* (Staff nurse)

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In contrast, physiotherapists were felt to encroach on the nurse's role within the ward, particularly in *'telling her what to do'* (Staff nurse), not valuing their opinions or knowledge or, most pejoratively, the nurse as *'someone who meets elimination needs'* (Ward sister). The traditional nurse-doctor relationship was also holding the nurse back:

> *'We still unfortunately have got a very traditional thinking team ... old fashioned ... The doctors expect the nurses to sit there and write the forms, bring them cups of tea and "yes, no" and wipe the brow, apart from one ... the nurses ... are still in that frame of mind. ... One particular girl ... she feels the doctor expects a certain level of performance from her and that level of performance does not include patient education, patient advocacy, any of those issues.'* (Ward sister)

> *'Eight times out of 10, whatever you say is ignored ... I don't think we have enough clout really, enough professional respect.'* (Staff nurse)

Even the specialist nurse commented that she felt like *'a cheap stop-gap for a failing service'*. This is consistent with the general comments within the nursing staff interviews of a *'feeling of being swamped'* due to staffing shortages and the nurse as *'the jack of all trades'*.

8.2.9 Making rehabilitation work

To make it all work in the rehabilitation area, however, there was a need for the right team mix. The nurse cannot rehabilitate the client without therapy specialists with the right knowledge and skills. Joint education sessions was one possibility or *'an educational programme for the staff which is multidisciplinary'* (Ward sister). Teamworking was seen as essential. This might be extended to mean that each takes on roles of the other, to *'cross over ... all mucking in together'* (Ward sister). For example, it did not need to be the nurse who took a client to the toilet. One problem lay with the working hours of non-nursing disciplines. The following comment from one nurse was typical:

> *'There is a complete lack of flexibility within the service ... specifically on the flexibility of working hours, and I don't think we're going to get that from anybody but the nurses.'* (Lead nurse, rheumatology)

8.3 Summary

Beginning with an analysis of the way in which the nurse assessed the needs of clients and carers, this chapter explored the actual role of the nurse in meeting those needs. The language used by the nurse in the assessment process, and its client focus, was of notable significance. There were considerable similarities in the informants' perspectives over the central role of the nurse, ranging from assessment, providing care to helping with the therapy, being a resource for the team and running the ward. At times the traditional rivalry between professions – therapy and nursing, nursing and medicine – was a common undercurrent. At others, nurses almost complain of a lack of clarity or of a confusion about their role in rehabilitation.

The range and rehabilitation content and potential of the nurse's role is well demonstrated in the case study examples given in Table 8.2. Specific professional roles are also evident, most notably within the community where the nurse involvement for those with rheumatoid arthritis would be expected to be primarily clinically focused (pressure sore care, continence and pain management). At the same time, the community nurse would provide ongoing assessment, then referring the client on for rehabilitation, along with liaising, co-ordinating and enabling rehabilitation to happen for the client.

CHAPTER 9

RHEUMATOID ARTHRITIS: UNMET NEED AND THE DESIRED ROLE OF THE NURSE

Key points

- A number of areas of unmet client and carer need were identified which had a negative impact on the rehabilitative experience. These included a lack of adequate and accurate information on the disease, medication and pain relief, a lack of GP involvement and a lack of emotional and social support.
- For several, it was the nurse who was seen by the client and carer as subsequently meeting the need. These included meeting needs for information and providing emotional support. The clients commented highly favourably about their contacts with nurses.
- Both the nurse and other members of the rehabilitation team perceived the desired role of the nurse as embracing more time, more knowledge and modification of the nursing contribution. Progress in each area would in turn meet the needs and expectations of clients and carers, especially for more individualised care.
- Therapists indicated that the nurse needed more time to carry on with therapy, to have greater knowledge about therapeutic techniques, and to extend the nursing role to meet clients' psychological needs, pain management and client education.
- Specialist nurses wanted to develop and improve the interface between the hospital and the community.
- Nurses drew attention to their need for more time to assess, do home visits, listen and counsel. Each would require additional knowledge and skills. They also wanted to change the nursing contribution, having less involvement in giving physical care and being more in the hub of the team. Their role in the rehabilitation team also needed greater recognition.

The previous chapter outlined areas where the nurse was meeting some of the needs of the client and carer. The data collection also identified a number of areas of unmet need, which will have a negative effect on the rehabilitative experiences of clients and carers. This is further compounded by the multiple contexts in which a person with rheumatoid arthritis may, or may not, want to receive rehabilitation input. This chapter explores areas of unmet client and carer need in relation to the actual and potential role of the nurse. It then identifies the desired role of the nurse, and by implication ways in which a change in the nurse's role within the multiprofessional and multi-agency team might result in a better meeting of those needs.

9.1 Areas of unmet need

Areas of unmet need are grouped into a set of interrelated categories (Figure 9.1):

- the need for information
- pain management
- GP involvement
- providing emotional and social support, accessing services and financial help
- lack of holistic care
- the carer's perspective.

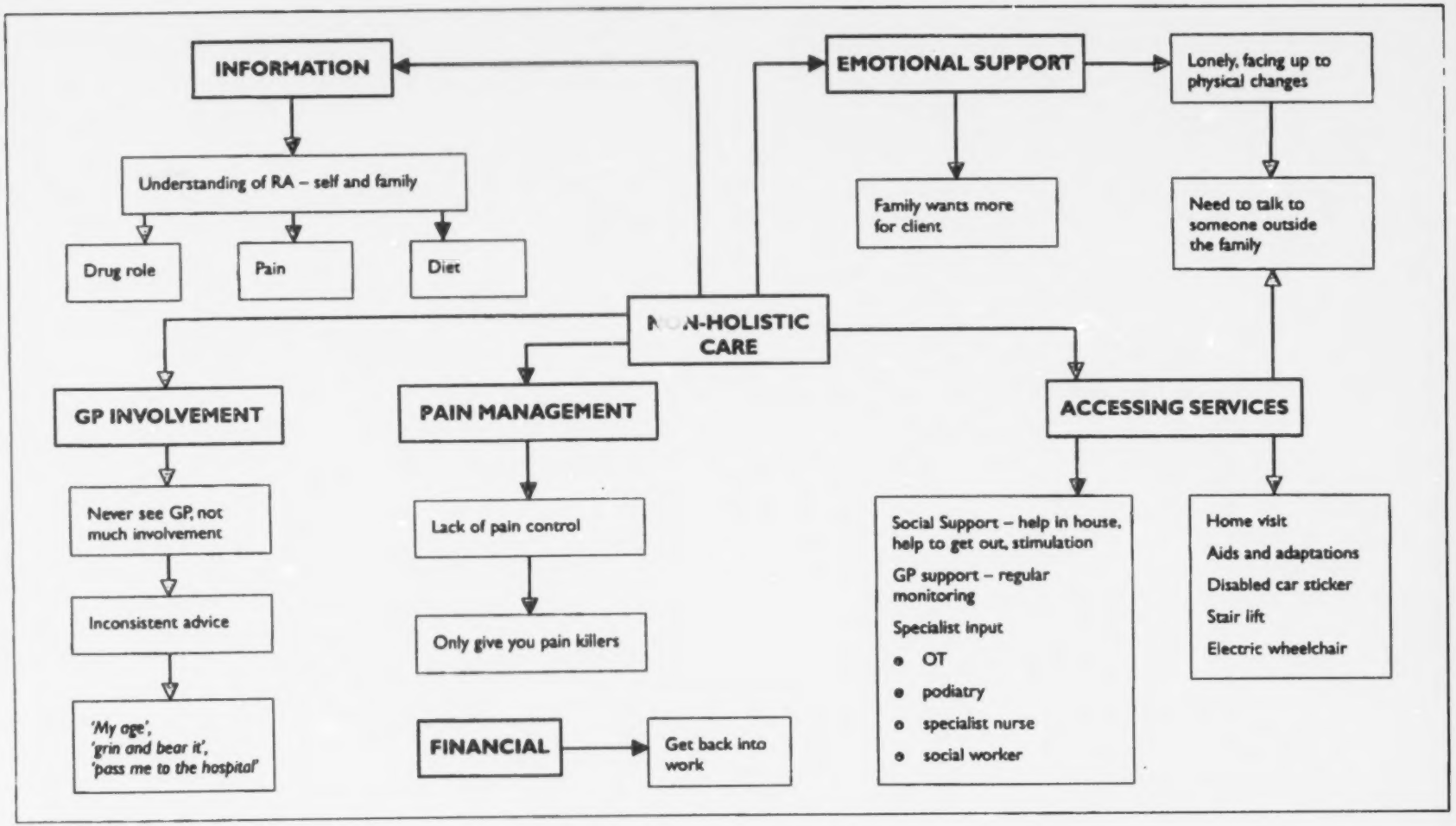

Figure 9.1: Client and carer unmet need – rheumatoid arthritis

9.1.1 The need for information

A key category centres on information needs. At its most general, informants expressed a desire for more information about the disease (to offset their lack of or limited understanding of what was wrong), the purpose of consultations, medication, and available services, for example, for help at home.

> *'I'm no wiser now than when I first went … The chap [doctor] asks you all sorts of questions, but you come away thinking, well we're no better off.'* (Mrs Gem)

> *'If I don't ask, then he don't tell me nothing.'* (Mrs Sapphire)

This contrasts with the provision of information (diet, ARC booklets) by the specialist nurse and a comment from Mr Crystal during his hospital stay:

> *'I've learnt more in three days [from the nurse] than I have in two years … Everything's brought down simple so [that] such a person as me can understand.'*

A specific area of need related to medication, in terms of providing effective pain control, information on side effects and how/when to take tablets. *'Nobody really explained to me'* complained Mr Crystal, but within the clinic setting, the nurse addressed this need, responding by giving information. Another area of need related to the role of diet.

While clients wanted more information for themselves, they also wanted it for their families.

> *'I've had no input for 20 years. If someone could talk to my family about what is going on, that would be good. They can't see how much pain I'm in and they don't really understand. Your family are going through it with you but they don't really understand or know how to deal with it. I don't want them to wrap me up in cotton wool … An outsider could explain why it is that one day you can do something, the next day you can't do anything. I can't explain it.'* (Mrs Topaz)

In another instance, following a query from the nurse, the client (Mr Crystal) indicated that his family did not understand about his illness.

9.1.2 Pain management

Unsurprisingly, pain management was a frequently mentioned need, and often not adequately resolved.

> *'I've always got pain in my feet, I go to bed at night and they are hurting, I get up in the morning and they are just the same … painkillers don't do anything.'* (Mrs Jet)

In some instances the comment was:

> *'All you get down there is "It's part of your illness … so all we can give you is painkillers".'* (Mrs Sapphire)

In others, relating to a stay in hospital where pain was very well controlled:

> *'They [the nurses] have a lot of patience, they understand old people.'* (Mrs Jade)

One client (Mrs Sapphire) was also seeking alternative approaches to pain management. Finally, a number of clients, in commenting about their expectations of their clinic visit, showed the realistic approach they were coming with, moving from *'at first a miracle cure'* to *'to try new painkillers'* or alternative coping strategies.

This category also links across to the area of a lack of holistic approach and/or continuity of care. As one client commented:

> *'I tell them I'm in pain but they're not discussing it. They just pass the buck and ask me when I'm coming into hospital.'* (Mr Crystal)

In another instance, inconsistent/contrary advice was being given by the GP and consultant (*'take more'* (Consultant) versus *'take less'* (GP) Mrs Ruby was told) which differed from the advice on the packet. Again, this contrasts with the way that the nurse specialist was providing information within her clinic consultations.

9.1.3 GP involvement

Three sorts of categories were apparent:

- a desire for greater involvement and support from the GP

> *'I've been really pleased with everything, except I've never seen my doctor. He's never been to see me and he's supposed to ... They don't bother.'* (Mrs Jewel)

Mrs Emerald's elderly sister commented: *'She can hardly walk and he has her going up to the surgery. He doesn't come to her ... I think that's a bit much'.*

Another client commented on what he expected:

> *'I think we could have done with more from our own GP ... When we talk to friends about it they say that you've got to pressurise them, and you've got to keep at them. Well I don't believe in that. We go to the doctors for the benefit of his knowledge and we expect him to advise us in that direction. And when they just say, "Oh, I'll give you a prescription for some more tablets," you just feel that you're wasting your time.'* (Mrs Sapphire)

- the poor interconnections between the GP and the consultant

There appears to be limited evidence of seamless care:

> *'If I go and say anything [to the GP] he says, "Tell Dr X".'* (Mrs Ruby)

- the actual role of the GP and the GP's attitudes to ill-health and old age.

> *'He'll say, "You've got to have patience, you know," and then he'll say, "Well it's your age," he says, "You're not getting any younger" ... So you just have to suffer it, you've just got to put up with the pain.'* (Mrs Ruby)

9.1.4 Providing emotional and social support, accessing services and financial help

A range of categories was evident here. Some related to the issue of accessing services. This included having greater support from the GP, *'The doctor looked at me ankles last week and that is the first time in two years, everything has just been left'* (Mr Crystal) and access and/or visits from specialist services (for example, OT, podiatry, nurse specialist and SW), and regular monitoring.

Others related to the provision of emotional, social and financial help. This included talking to members of the family about the disease, its treatment and associated pain. On the emotional side, clients either felt unable to tell their family about how they felt or just felt the need to talk to someone from outside of the family:

> *'Sometimes it's good to talk, to let it all out. You see, I can't talk to my husband like I have to you – he's got enough to worry about.'* (Mrs Garnet)

She continued that she felt too exhausted to go out, but was lonely and wanted to see people.

Two other illustrations of this area of unmet need arose within the clinic observation work. Each occurred perhaps as a result of, or was compromised by, the pressure of time or caseload within that setting. In the first, by the time she saw the sixth clinic client, the specialist nurse passed over the evident emotional state exhibited by the client's wife, who appeared to be close to tears. In the second, in the nurse-practitioner's clinic, run so that she had more time to spend with clients, two clients were both close to tears. This was again either not noticed or not acknowledged. After the clinic, both nurses commented that counselling was not part of their role and in any case they was little or no time to do this within clinic work.

These two negative and disquieting examples must, however, be seen in context. They relate to the experience of just two of the 40 or so clinic clients observed. Contrast with a period of observation undertaken in the medically-led clinic is instructive. The observer noted the speed of the consultations (*'there was little time given for the client to ask questions'*) and the lack of attention to the emotional needs of the client. Taken together, the observer's comments on the nurse specialist and consultant-led clinics are highly pertinent:

> *'They both began being very attentive to the clients, but as the clinic wore on they became less sensitive to client cues and comments.'* (Observer)

This contrasts sharply with observational data on the specialist rheumatology nurse's visits to clients when in hospital or visiting them at home – a seemingly less pressured situation. For example, in the ward setting, the nurse raised the question of polymedication, itself suggestive of taking a more 'holistic' approach to care. Similarly where the nurses were able to manage their caseload, they could follow up clients' questions and queries in more depth, for example, returning clients' calls to the nurse helpline.

On a social level, the need for support ranged from the need to meet others (*'we have no visitors at all, we've got to the stage that we look forward to the chiropodist coming'* – Mr Amber) to the need for additional help to support the individual at home. An elderly carer complained:

> *'They think that because she has me she doesn't need any help. I used to sleep on Sundays as well but three nights on the couch, it's a bit much, because I'm 81 and I've had two hip operations.'* (Mrs Emerald's sister)

Or, as the daughter of another client commented:

> *'It would put my mind at rest if there was someone who was coming in who knows what they're doing and if we're doing something wrong.'*
> (Mrs Diamond's daughter)

Yet another client (Mrs Topaz) wanted help to get out of her house. Another younger client wanted more external help to assist her husband on whom she relied (Mrs Garnet).

9.1.5 Lack of holistic care

Although clients were treated and cared for as individuals, there was a concern over the routinised nature of care especially within the hospital context. One client commented:

> *'Over there [in the rehabilitation ward] ... the philosophy is, "Don't let them go to bed, except when it's time to go to bed" ...'* (Mr Opal)

Several mentioned that: *'All you get down there is ... painkillers. But I don't want painkillers'* (Mrs Sapphire).

9.1.6 The carer's perspective

While only a small number of interviews were carried out with the primary carer of the selected rheumatoid arthritis clients, additional information was gleaned from the client interviews. While a number of common areas of need emerged, a different emphasis seemed to be placed depending on the age of the client and carer and whether the primary carer was a husband or wife, or another relative.

Of the younger clients (there were four aged in their 30s or 40s), in one case the husband had given up his job to look after the client (Mrs Garnet). The client herself felt guilty, that she was a burden, but she did not want *'a stranger'* looking after her. For another (Mrs Topaz), her family as a whole were giving her substantial support, her daughter with the meals and her husband adaptations around the house (banister and shower). For both, no particular unmet carer needs were evident at that time.

One older carer needed help if her 74-year-old husband was to go outside. They only had a push wheelchair, and *'she gets puffed out when [she pushes it]'* (Mr. Amber) (although an electric wheelchair has been promised).

Again, in the case of Mrs Emerald's elderly sister as carer, she commented that: *'They [health and social services] think because she has me, she doesn't need help'.* The sister stays every weekend, sleeping on the couch. *'But I'm 81 and I've had two hip operations.'* She wanted more help for her sister. At the same time, Mrs Emerald confided to the interviewer that she would rather go into a nursing home than make her sister come live with her, or become more burdensome to her.

Finally, Mrs Diamond's daughter wanted her 78-year-old mother to have: *'... More of what [the specialist rheumatology] nurse ... did. I'd like to see her come once, perhaps twice, a year to see her'.* She wanted the specialist nurse to assess her mother and to advise on other ways her mother could be helped.

For these carers, both young and older, spouse or other relative, areas of unmet need were evident. The overwhelming impression was that if these carers had not provided their support the client would either have substantially greater (unmet) needs or would have required formal home-care support services to manage in their own home. Simply stated: *'If anything happened to my husband, I'd be stuck'* (Mrs Jewel). Mr Stone was already receiving substantial support from social services. For Miss Coral, whose main carer was an elderly sister living a few doors away, the SW was researching what additional packages of care could be provided at home. However, whether the needs of the older carers had been assessed, and by whom, was not discovered. It is important to note that while the statutory responsibility for assessing carer need falls on social services, there is a potential role for other team members, in particular the nurse, in ensuring that such an assessment has been undertaken.

9.1.7 Summary

These findings point to a number of areas of unmet need, for example, information, pain management and emotional/social support. Although it might appear that the clients' needs were not met, this was not the case, as was outlined in Chapter 8. Examples included the provision of practical help via the home help, home adaptations, physiotherapy, having time spent on them, arrangement of services by the district nurse, the support of the consultant (and for one of the GP), and the highly positive comments of clients about their contacts with nurses. In addition, all the rheumatoid arthritis client case studies pointed to the significance of the first and/or subsequent contacts with the specialist rheumatologist or associated hospital (nurse specialist) staff. In all cases, access to home-based services, rehabilitation and sources of information were facilitated through the hospital visit.

9.2 The desired role of the nurse

The areas of unmet need can be considered within a wider context of the potential and desired role of the nurse within the multiprofessional and multi-agency rehabilitation team. In many cases, the needs may have been identified. A variety of factors may account for their not being adequately resolved. A change in the role of the nurse may itself facilitate the meeting of these needs.

Ways in which informants perceived the desired role of the nurse are summarised in Table 9.1. The views of the nurse and other team members are juxtaposed against some of the unmet needs of clients and carers.

Desired role of the nurse from the perspectives of the:		**Expectations/needs of clients and carers**
Nurse	**Multiprofessional team**	
More time for: • assessment • home visits • listening • counselling • outpatient appointments	More time to: • carry on therapy • work towards shared client-focused goals • assess	Need for: • more individualised care • someone to take initiative to support the carer, *'to check things are being done right'* (Relative of Mrs Diamond) • more home visits
More knowledge about: • counselling skills • pain management • assessment • sexual health • complementary therapies	Need for: • nurses to have greater skills and knowledge on therapeutic techniques (joint protection, transfers, equipment) • need more therapy staff to enable cross-fertilisation of skill and knowledge	Unmet need for: • access to services and aids/adaptations • regular input from specialists • specialist multiprofessional approach
To change nursing contribution: • less involvement in giving physical care • enhance skills • be more in the hub of the team • develop seven-days-a-week service interfacing with the community • health care assistant	To expand the nursing contribution in: • meeting psychological needs • management • client education	Need for: • better and more effective pain management • more information • more education
Closer teamworking: • liaison • shared skills		
Greater recognition		

Table 9.1: Perspectives on the desired role of the nurse

For specialist nurses, greater time (a smaller caseload) would enable them to meet identified client and carer needs more closely. This included time for home visits, to listen more closely to clients and in particular to meet their psychological needs. A *'forward-thinking, independent nurse'* was needed.

The nurse was also generally perceived to be best placed, particularly in the community setting, to provide more information and client education and information. This encompassed smoking, diet, general information, self-management and the need for compliance with treatment.

Moreover, the nurse could be more proactive in encouraging and implementing joint documentation and joint goal setting. Instead, at present, the nurse was not looking as closely as she might at the goals of other team members, although a physiotherapist said: *'Maybe it's our fault ... not brought it to their attention more'.*

For other members of the multiprofessional team, nurses within the hospital context needed more time to *'carry over'* the therapy exercises and to enable them to work towards shared and client-focused goals. The nurse was seen as having the skills and knowledge, but:

> *'One, they don't always have the time, the main reason, and two, they don't always have the confidence ... Or, three ... some of the nurses that have been here for many years, they are so stuck into their way of doing things.'* (Physiotherapist)

To take on this wider role in rehabilitation both the nurses and other team members saw the need for more knowledge, although the specific content varied. For the nurses, pain management and counselling featured highly. One staff nurse pointed to the need for the skills of patience, communication, understanding of pain and its management and patient education. For the therapists, the emphasis was on extending the knowledge and skills of nurses in therapeutic techniques, in particular, for joint protection, transfers and equipment. More therapy staff was also seen as necessary to provide the opportunity for nurse education. The contrast with the client's perspective is noteworthy. Client and carer concerns lay with access to aids, regular inputs from specialists (including the nurse specialist) and a multiprofessional, perhaps more seamless, approach.

Nurses also pointed to two other changes with implications for their role: better teamworking and greater recognition of their current and potential contributions. For example:

> *'We have multidisciplinary team meetings, that improves ... the relationship.'* (Staff nurse)

> *'... A way of improving things would be to have more joint working ... more observations of different professionals ... My experience of watching wards and talking to people ... when a new staff nurse comes to a ward she doesn't usually work with the OT or physio, she just gets stuck right in the nurse's end.'* (OT)

Extending knowledge and skills would provide a necessary condition to enable a change in aspects of the nurse's role. For some, this involved extending the nurse's role, including enhancing the role of the HCA as a generic rehabilitation worker.

> *'They don't have defined lines at the end of roles because they have the whole role.'* (Specialist nurse)

They can thus implement the whole plan, given the right training. For others, it would mean less involvement in giving physical care. As for joint activity, client education was one fruitful area:

> *'... The education side is definitely an overlap ... We could work a lot more closely on that.'* (Physiotherapist)

Perhaps the final and appropriate bottom line was a desired role comprising greater recognition of the skills, knowledge and actual and potential contribution of the nurse within the rehabilitation process for the client with rheumatoid arthritis.

9.3 Summary

This chapter has drawn together the data on the unmet needs and desired role of the nurse within the multiprofessional and multi-agency team. While the data collection uncovered a number of areas of unmet need, the comments of the nurse and other members of the rehabilitation team suggest that many of these might be addressed with a changed role of the nurse. The most striking area in this case study area was the nurse adopting even more firmly the role of co-ordinator, liaison or the person who makes rehabilitation happen. This is particularly important when the client is outside the hospital. There was also the need for *'more time'*, both for and by other members of the multiprofessional team and the nurse. This was similarly important for the client and expressed in terms of *'more individualised care'*. To adopt a wider role, the nurse would also require more knowledge and skills.

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Key points

- The 17 clients varied in age from 39 to 92, with a median of 67 years. They comprised seven men and 10 women.
- The cameos of their care pathways exhibit considerable variety, with no clear pattern. The client's experiences of rehabilitation vary due to the different directions that they take. All but five of the clients returned to their own homes. One died and four were discharged into nursing homes.
- A wide range of settings was observed, highlighting the variety of service provision, which could be accessed at some stage by clients. These included acute medical wards, a faster-stream general rehabilitation ward, a general rehabilitation and rheumatology ward, a young disabled unit, a stroke unit, a community rehabilitation team and nursing homes.

This chapter describes the stroke clients and the settings in which they experienced rehabilitation and nursing care. Its aim is to situate the findings within the context from which they were drawn.

10.1 The clients

The 17 clients varied in age from 39 to 92 with a median of 67 years and comprised seven men and 10 women. A brief cameo of each client is presented below, demonstrating the variations in the care pathways followed by the clients.

Mrs Red, aged 84, had lived alone since the death of her husband six years ago. She was admitted to an acute medical ward following a stroke. Her daughter visited her regularly before the stroke and after admission. Mrs Red developed a chest infection and a bowel infection (clostridium with severe diarrhoea). The stroke had left her with a weakness on the left side but she could communicate well with others. After eight weeks on the acute medical ward, she was transferred to a rehabilitation ward where she stayed for a further eight weeks before moving into a nursing home. While Mrs Red described the staff on the rehabilitation ward as *'too bossy'* and *'treated us like kids'*, her daughter was more satisfied. She felt that in comparison to the acute ward, where she was given very little information, she was more supported and involved by the rehabilitation staff. This was particularly so when she decided that she could not care for her mother at home. After one month, Mrs Red was discharged to a nursing home. Mrs Red was coming to terms with the situation and had mixed feelings about going into a home. In the nursing home, Mrs Red had her own room with access to onsite occupational therapy, a library and a hairdresser: *'there's always laughter, we have a good time'*. Mrs Red's daughter knew that her mother was in the best place, but felt guilty at having made the decision.

Mrs Yellow, aged 75, had three strokes in 1998, the last of which was in March. She spent several months on a general rehabilitation ward and was discharged to sheltered accommodation with 24-hour warden cover. However, on two of the researcher's visits, the warden was not present and Mrs Yellow could not answer her intercom buzzer to enable entry into the building. On discharge she was referred to the community stroke team to try and improve her severe left-sided hemiparesis and expressive dysphasia. This continued along with regular contact with the district nurse and OT. The social services carers visited every morning and evening, to help with personal hygiene, elimination and meals. However, when the social carer failed to arrive on two occasions, Mrs Yellow described feelings of helplessness where all she could do was *'scream and scream'* in order to attract someone's attention.

Mr Green, aged 79, was admitted to an acute medical ward where he stayed for two weeks before being moved to a general rehabilitation ward. His stroke had left him with a mild weakness down his right arm and leg although he required minimal assistance. He was discharged home with a zimmer frame to aid his mobility.

Mrs Purple was 57 when she had her stroke in February 1998. This left her with almost complete expressive dysphasia and a dense left-sided hemiparesis. Her husband was her full-time carer but in the last six months had himself become ill. After discharge from the rehabilitation ward Mrs Purple was referred onto the community stroke team. Over the initial period, Mrs Purple received physiotherapy input twice a week, speech and language therapy every few weeks as well as care from the social care staff. She cancelled these herself as she felt they were not helping and did not like the social care staff. Her husband, Mr Purple, was disappointed with the speech therapy service, which was sporadic due to staffing shortages. The district nurse was a very important and regular contact. The OT had also been involved in teaching the couple as well as organising adaptations and 'ring and ride' services. However, there was a year-long wait for a downstairs shower to be built by social services. Mr Purple found full-time caring an increasing strain, particularly as he was carrying his wife up the stairs for a wash or using a small bowl.

Mrs Blue, aged 39, was admitted to a busy acute medical ward where she described being very lonely. She was transferred to a heart rehabilitation ward for a short period before being discharged home with the support of the community stroke rehabilitation team. The stroke team concentrated on her mobility, speech and social interaction needs. The visits from the auxiliary on the team were very important as they gave Mrs Blue time to talk when she was down and also provided company. She then went home to her husband and two young children and gradually developed new methods of doing various aspects of the housework and cooking. Her left-sided hemiparesis and expressive dysphasia continued to improve, although her social isolation did not.

Mrs Black, aged 75, was admitted to an acute medical ward after suffering her second stroke in one year. After her first stroke, Mrs Black spent an unhappy period in a rehabilitation unit where the care she experienced seemed to hinder rather than help her recovery (*'more a sentence than being helped'*). Both she and her family vowed that she would never go to rehabilitation (ward) again. When she got home after her first stroke, she still had a severe left-sided hemiparesis but was able to manage some aspects of her own care. Her husband and daughter were the main carers and took her out shopping and playing bingo. Her second stroke affected the right side of her body and left her with dysphasia, dysphagia and bilateral hemiparesis. The hospital staff felt it likely that the discharge destination for Mrs Black would be a nursing home. Mr Black was not happy with this and said he would *'fight it'*. After being on the ward for 12 weeks, with much family pressure and the support of the SW (who was *'a tower of strength'*), Mrs Black went home to be cared for by her family. Support at home was provided by the district nurse, social services carers and the SW. Mrs Black required constant care to manage her elimination, nutritional and hygiene needs, and pressure area care. Mrs Black's daughter gave up work to do this with the help of her father. The family obtained a wheelchair and hoped to take their mother outside in the summer.

Mr Cream, aged 77, was admitted to a busy acute medical ward after a stroke in October 1998, where he was nursed by a team led by an NVQ Level 3 HCA. The charge nurse of this ward commented that standards of care were often felt to fall below an acceptable level due to staffing problems. Mr Cream stayed there for a month, where his hemiparesis was very dense and sitting balance was a major problem. His wife was having difficulty visiting the hospital due to her own illness and because she did not drive. Mr Cream was then admitted to a rehabilitation ward where he progressed very little. He stayed there for two and a half months before moving to a nursing home. The SW arranged 'ring and ride' access for his wife to visit. Mr Cream seemed a lot happier and relaxed at the nursing home. Although the environment was very much like a hospital ward and was in the process of being renovated, the nursing staff seemed keen to make the place as homely as possible.

Mr Russet, aged 76, was admitted to an acute medical ward where the nurses were *'very helpful'*. He had a severe hemiparesis, incontinence, slurred speech and initially some difficulty swallowing. He was referred in the first two days to the speech and language therapist and dietitian. He began naso-gastric feeding until his swallowing ability was regained. Following a 12-week stay on the acute ward, Mr Russet was transferred to a rehabilitation ward where he stayed for six weeks. He regained very little physical function, or sitting balance in his left side, and became very 'low' as he realised the level of his disability. There was a case conference, and subsequently Mr Russet was transferred to a nursing home. There he used a wheelchair and required help with many daily activities. He continued to miss his own home.

Mr Grey, aged 52, had a stroke in September 1998 and spent about two weeks on an acute medical ward. He was transferred to a general rehabilitation ward where he stayed for two and a half months. Mr Grey was very anxious to get home as he felt as though his life was on hold while he was in hospital, apart from the 10 minutes of physiotherapy each day. On discharge home, Mr Grey was able to walk with the aid of a walking stick. His speech was slurred but understandable and improving. Mr Grey received the support of the community stroke team. This included speech and language therapy, occupational therapy, nursing and support worker cover. Physiotherapy was provided by the hospital outpatient department. However, his own expectations of progressing further with the support of the team were not met as the care they provided did not appear to meet his needs. Mr Grey initially had daily visits from a social services carer in the morning. Some family lived close by, although they were not able to provide much support.

Mr Navy, aged 71, had his second stroke in two years in November 1998. He was admitted to a busy acute medical ward where he spent his entire hospital stay. He was discharged to his own home in January 1999 with few new problems. He lived with his handicapped 30-year-old son. His older son and wife were the main carers for them both. Both Mr Navy and the younger son received the help of social services carers. The older son felt that everything was *'a struggle'* and wanted more help. He found it hard to look after his own family, work part time and see that his father and younger brother were all right.

Mrs Brown, aged 42, was admitted to an acute medical ward in December 1998 from a high dependency unit (HDU) after suffering a right cerebellum infarct. It was planned that Mrs Brown would spend a short time on the acute ward before moving to the rehabilitation unit or younger disabled unit. However, it transpired that she was not eligible for a place in the rehabilitation ward as she lived just outside the catchment area. As such, she received all of her inpatient care on an acute medical ward. She was discharged from hospital just before Christmas but still had problems with her eyes and balance. She walked using a zimmer frame under supervision. The physiotherapist helped with mobility and confidence. An intercom system provided by the community OT meant that Mr Brown could hear his wife upstairs if she called him. The district nurse visited initially to treat the head wound. She became able to walk without the zimmer frame. Mr Brown said that he alone prepared himself for his wife's discharge. He remembers thinking to himself, *'While I'm here, I'm going to watch everything, I'm going to learn as much as I possibly can … I thought I could look after her better … no disrespect to the nurses … they've not got the time'.*

Miss White, aged 55, had a stroke that left her with blindness and a dense left-sided hemiparesis. After spending 14 weeks in hospital, she was discharged in January 1998 with the support of the community rehabilitation team, social services carers and specialist neurological physiotherapy. The OT and support worker from the community stroke rehabilitation team visited her two or three times a week and reinforced the physiotherapy. Miss White described the co-operation between the community physiotherapist and OT as *'terrific as often these two don't get on'*. Miss White's son also visited every week. The social services carers came every morning and night and helped her to wash and dress and with a meal. Although Mrs White's mobility was very restricted, it was her sight that she missed most. She wants to go out but is almost completely restricted to one room of her house. She was experiencing financial difficulty and could not easily afford to pay for a taxi and escorts to help her get around. Sadly, Miss White was 40p above the threshold for night-time assistance which left her angry and upset.

Mrs Lilac, aged 92, had a stroke, and was cared for at home by her daughter with the input of the GP. After struggling at home for a number of weeks, Mrs Lilac's daughter asked for her mother to receive rehabilitation services. She was admitted to a rehabilitation ward for assessment and a time-limited period of therapy. Mrs Lilac was discharged home at her daughter's request after four weeks, because of the lack of therapy and the negative effect of the institutionalised setting. After some time at home during which the daughter struggled to cope with no physical or emotional support from district nurses or GP, Mrs Lilac was admitted to a nursing home where she later died.

Mr Charcoal, aged 76, had a stroke in early January 1999. He was admitted to a general rehabilitation ward after 10 days on a medical ward, with a left-sided weakness and loss of mobility. This was his chief concern, particularly as it was several weeks before he received physiotherapy. He stayed on the ward for four months before being discharged to a nursing home for a two-week period while repairs were made to his home. He was then re-housed

in sheltered accommodation. He did not receive any health or social services support. A Stroke Association worker left him a contact number in case he needed any advice or information. Although he had not needed to contact them, he felt it was useful to have the option as it gave a sense that *'somebody is interested'* as the *'official people'* did not seem to be. He started with a new GP.

Mr Turquoise, aged 59, was admitted to an acute ward where they *'didn't have time for rehabilitation really in there because it was one test after another'*. He stayed there for a week until he was admitted to a stroke unit. Mr Turquoise liked the relaxed atmosphere of the stroke unit and the friendly interaction with the staff, but felt bored during the day. Mrs Turquoise was desperate for her husband to come home. His stroke affected his mobility and he required the assistance of two people to transfer. He was referred to the speech and language therapist for dysphasia. Mrs Turquoise was encouraged to attend therapy sessions and Mr Turquoise went on a number of weekend home visits. With strong support from the consultant, he was discharged with three visits a week to the community physiotherapists. This was gradually decreased to once a fortnight. When interviewed at home, Mr Turquoise was using a borrowed wheelchair as there was a 24-week wait for a wheelchair. He was not happy about this, although his mobility was improving. His wife was having some difficulty claiming the appropriate benefits. On hearing this, the SW advised them to contact the Citizens Advice Bureau. There was no GP involvement.

Mrs Pink, aged 62, was admitted to an acute medical ward at the beginning of April 1999. She was then transferred to the stroke unit for rehabilitation, but contracted pneumonia and was moved back to the acute medical ward. When she had recovered from the pneumonia, she moved again to the stroke unit. Mrs Pink had a severe left-sided hemiparesis, but no cognitive or communication difficulties. She became very withdrawn on the stroke unit. Mrs Pink stayed there for four months. Her daughter described some of the nursing staff as unfriendly and uncaring, and complained that they did not give her enough information. Mrs Pink was discharged in August to a nursing home. Her daughter became much happier as did her mother, with her own room, television, kettle and regular bingo sessions. The daughter had a good relationship with the nursing home staff and said nothing is too much trouble for them. There had been a problem with the financial side, sorting out the nursing home bills (£600 a month). After paying the fees, her mother only had £14 per week. In September, Mrs Pink was assessed for an electric wheelchair and received it in January. It made a great difference to Mrs Pink's life and she said she had *'a lot more freedom'*.

Mrs Orange, aged 81, was admitted to the stroke unit in June 1999 after only four days on a medical ward. She had suffered a mild stroke and did not require any nursing assistance, physiotherapy, speech and language therapy or occupational therapy after the first few days. She stayed in the stroke unit slightly longer than necessary until her daughter had returned from her holidays. She very much appreciated this. Mrs Orange's daughter stayed with her mother for two weeks after her discharge. She continued to cook her meals and do her shopping for her. Mrs Orange said that her speech was slightly slower and her left hand weak, but there have been no real problems since her stroke.

10.2 The settings

A1 Acute medical ward

This comprised a 29-bedded medical ward with modern décor, with three bays and three side rooms. Each bay had a nursing station and there was also a central nursing station at the entrance to the ward. There was a client day room with a television. It admitted male and female cardiac and other 'medical' clients.

The nursing care of clients was led by the E-grade 'named nurse' whose name was shown above the clients' beds. Each named nurse took a team of clients (all located within one bay) while auxiliary, support worker staff and D-grade nurses moved between the client teams. Nursing care plans usually comprised a combination of pre-written and individually-written plans.

Three consultants were linked to the ward. The physiotherapist covered three other additional wards while occupational therapy staff members were linked to the consultants. Other members of the multiprofessional team (for example, speech and language therapist,

dietitian) could be contacted at the central department for the hospital. Two consultants held multiprofessional team meetings while the third doubted their value, as all team members could rarely attend the meeting. Case conferences could be set up if clients' relatives wanted this or if the plan of care was very complex. Notes were not shared among members of the health care team although physiotherapy and occupational therapy staff members tended to write in medical notes as well as their own where they felt necessary. SWs wrote in the nursing notes.

A3 Acute medical ward

This was a 22-bedded, male acute medical ward, covered by three consultants. The ward had its own philosophy, including a commitment to the provision of high quality information and education to clients and families to enable informed decision making, research-based practice and effective co-ordination of care.

According to the ward manager, the ward was characterised by poor staffing levels. She had implemented a system to monitor standards of care. Multidisciplinary meetings were generally accepted as *'too time consuming'* when staffing levels were low, as all team members could rarely attend. The staff nurses were heavily reliant on well-trained HCAs. The charge nurse stated that an increasingly large amount of nurses' time was spent on technical tasks such as cannulation, drug preparation and administration, as a result of reductions in the hours of junior hospital doctors.

Physiotherapy and occupational therapy input onto the ward was minimal and clients were frequently taken off the ward for treatment. Nurses received little feedback on this activity. Hand-over from therapy staff was informal, although occupational therapy staff members wrote in the medical notes.

C1 Acute medical ward

This ward consisted of 29 beds, split about equally male and female. The ward received a broad range of clients, but only rarely clients with cardiac conditions. According to the ward sister, qualified staffing levels were usually one down from the desired quota per shift. As such, much of the hands-on care was delegated to support workers. The ward philosophy was very general, mentioning the need for skilled staff to provide holistic care.

Members of nursing staff typically bemoaned the basic standards of care that they were able to provide. Staff members reported that clients were often left in bed as nurses were too busy to get clients up and supervise them. Some nurses also feared helping clients to stand in case of back injury. The input from physiotherapy and occupational therapy was described as *'10 minutes a day if clients were lucky'*. Some of the qualified nurses fulfilled a dysphagia link nurse role and were able to assess clients for swallowing problems.

The ward had recently attempted to introduce primary nursing. This had been difficult due to staff holidays and off duty requests. Previously nursing care had been organised by a mixture of task allocation and team nursing. Links with a lecturer-practitioner had helped to develop the ward, introducing new care plans and trying to improve discharge planning.

A4 Faster-stream rehabilitation ward

This 19-bedded, mixed sex general rehabilitation ward admitted clients with a wide variety of conditions and rehabilitation needs. A dedicated rehabilitation team (including a social therapist) contributed to a service that was predominantly Monday to Friday. The ward was at one time managed by a physiotherapist while the F-grade position was filled by a nursing member of staff.

Nurses arranged their work around the two sides of the ward, trying to work on the same side where possible. In contrast, the physiotherapist and OT worked separately and saw

whoever they felt necessary. While all professional groups wrote their own notes, the notes were kept together in one client folder. Most of the communications between nurses and therapy staff occurred on an informal basis, as members of therapy staff did not always attend the midday nursing hand-over. Signs above clients' beds in relation to mobility, moving and handling and washing and dressing aimed to enhance the consistency of care clients receive. Case conferences were held weekly.

While being committed to rehabilitation, the traditional Nightingale layout of the ward did little to promote rehabilitation or independence. Bathrooms and toilets were very small, with few adaptations. There were no dedicated rooms for therapy, client recreation or team meetings.

The rehabilitation service philosophy, (in common to the A5 rehabilitation unit – see below) advocated the benefits of a multidisciplinary assessment and treatment plan. It spoke of a commitment to clients and families being able to make informed decisions regarding treatment and discharge, research-based practice and co-ordinated care to enable safe discharge.

A5 Rehabilitation unit

This 15-bedded unit was purpose-built to cater for clients with more complex rehabilitation needs than A4. It admitted clients with a variety of conditions, but particularly strokes. Clients stayed an average of two to three months.

Treatment co-ordinators – the physiotherapist, OT or F-grade nurse – assessed clients around the hospital for suitability for admission to the unit, with potential clients being discussed weekly. Multiprofessional team hand-overs occurred once a week. The remainder of the time, communication between nurses and others was informal and via client notes. Each professional wrote their own notes and these were kept in a single folder. Notices posted above the bed, for example, in relation to moving and handling and washing and dressing, aided specific communications on client care. Monthly client case conferences involved the whole team, client and family. Despite this, communication was an area acknowledged as requiring development.

The unit's physical environment was conducive to rehabilitation. It had a large lounge, dining room area, therapy rooms with equipment, adapted bathrooms, toilets and showers, individual bedrooms and four-bedded bays and patio area. However, some clients found a lack of buzzers problematic in some areas. This meant that some clients were not safe if left alone in rooms.

C2 General rehabilitation and rheumatology ward

The ward admitted clients with a variety of rehabilitation needs arising from different conditions such as stroke, Parkinson's disease, falls or long-standing medical problems and rheumatological conditions.

The ward was divided into male and female ends split by the nursing office. At the female end there was a mixed dining and recreational area. The physiotherapy gym and the occupational therapy kitchen and flat were situated slightly down the corridor. The flat was poorly used due to a skeletal occupational therapy service.

The philosophy of care for the rehabilitation ward expressed a desire to provide a multidisciplinary approach to care in order to facilitate client and family involvement, self-care and optimum levels of independence. However, staffing problems plagued this ward during the fieldwork. There was a notable shortage of physiotherapy and occupational therapy staff. This left the nurses feeling frustrated. Treatment plans were not modified quickly enough as clients' status changed.

Clients accessed the rehabilitation ward via telephone referrals from nurses or other members of the health care team on other wards around the hospital. A member of staff from

the rehabilitation ward (either an E-grade nurse or therapist) would go to the referring ward to assess the client. The decision whether to admit the client was made on the basis of a Barthel assessment, Mini-Mental State test, and prediction of meeting long- and short-term goals. Once admitted, nurses and therapists set joint goals with the client and met at weekly team meetings. Care planning used the Orem model of self-care. It was described as leading to a 'co-ordinator role' for the nurse. Client notes were partly shared between the nurse, OT and physiotherapist. They all contributed to a central set of notes.

C3 Young disabled unit (YDU)

The philosophy of the unit emphasised the importance of providing the service in a homely setting, while maintaining high standards of medical, nursing and therapy input. The environment contained individual rooms, a pool table, TV, dining area, smoking area, a laundry room for relatives to use, and a garden for use in the summer provided extra space and freedom. Many clients had electric wheelchairs.

Admission to the unit was based on Barthel scores and more recently, scores on the Functional Impairment Monitoring (FIM) and the Functional Assessment Monitoring (FAM) tools. Members of nursing staff used the Northwick Park Dependency Scoring system to monitor nursing workload levels and adjust inpatient/staff numbers as required.

Nursing work was organised via nursing teams led by an E-grade nurse, and supported by a D-grade nurse and support worker staff. Therapy staff members planned discrete periods of timetabled therapy for clients. These timetables were also provided to clients and their families. Recently, occupational therapy cover had been provided on Sundays as well as on weekdays. A specific occupational therapy kitchen and live-in flat for the staging of discharges and a therapy gym aided the rehabilitation process.

F1 Stroke unit

This 24-bed unit (four bays) provided dedicated stroke care, often from the acute stage of the disease onto rehabilitation. As well as including the usual core members (physiotherapy, OT, speech and language therapy) the rehabilitation team was notable in including a representative from a user and carer organisation to act as a carer support worker. Unlike other rehabilitation settings (bar the YDU), this unit also had dedicated psychology cover.

Although the more senior members of the therapy staff were permanently based on the ward, other staff members rotated from other parts of the hospital. This was noted as leading to some difficulties in teamworking.

Admission to the unit was via a referral to the stroke assessment team. Clients with stroke in the main hospital were assessed by the stroke team who advised ward staff on care and treatment. No formal assessment tools were used to aid this decision making. Clients stayed on average two to three months on the unit. Regular discharge planning and case conferences aided the discharge process and ensured contact with relatives was maintained.

Client notes were shared by members of the multiprofessional team. Team hand-overs occurred at lunchtime. Teamwork between nurses and therapy staff was aided by instructions that were hung above clients' beds. Case conferences and family meetings occurred weekly. Nursing care was organised around a primary nursing approach.

The ward had many link nurse roles covering areas such as continence, discharge planning, nutrition and wound care. In addition, educational resources for staff and students were readily accessible and in-service training sessions, given by various team members, occurred monthly.

The community stroke team included nursing, support work, speech and language therapy and occupational therapy. Community physiotherapy was provided separately from the team. The team provided both short-term and longer-term support to clients in the community with stroke, and received referrals from the hospital (Trust A), GPs, carers and other team members, such as the OTs and SWs. Support was geared towards physical functioning and prevention of crisis and readmission to hospital. It also involved providing emotional support and referral. The team operated Monday to Friday. It had close links with district nurses who provided weekend cover.

Nursing and residential home 1

This private home was part of a large chain. It accepted clients requiring residential, nursing and elderly severely mentally ill care. There were 30 beds in the home on one floor. Typically the home was staffed by one or two qualified nurses, with the support of four to six care assistants. The home linked with the rapid response team and community occupational and physiotherapy services. The home had a residents' committee, hairdressing, regular entertainment and gardens.

Nursing and residential home 2

This home accepted both nursing and residential clients. Recently the home was sold to a large company and a staff development unit for qualified and unqualified staff was established. The home had 32 beds on three floors. On a usual shift one qualified nurse supervised five care assistants. The home offered hairdressing, a library, entertainment, manicurist, and also had a patio and gardens.

Nursing and residential home 3

This was a home supported by a charity, and was non-profit-related. It could take 14 residential and 56 clients with nursing needs. The beds were on two floors, and rooms were communal. The home was being redeveloped to provide private rooms.

10.3 Summary

The client profiles demonstrate that there is no clear pattern of care pathways that clients follow after a stroke. While this does not demonstrate the needs of each client, and only briefly outlines the support available to them, clients' experiences are likely to vary simply due to the different direction that each follows.

The settings highlight the breadth of service provision available, which were all accessed at some stage by the clients who were included in the study. Between them, the acute medical wards, rehabilitation and stroke units, a young disabled unit and a community rehabilitation team and nursing homes reflect the combinations of care settings for a client following a stroke.

Key points

- Nurses fulfilled a vital role in the initial and ongoing assessment of client need. Assessment was both formal and informal over a broad range of areas. Other contributions included providing physical help, emotional support, clinical nursing care, integrating therapy into activities of living, carrying on therapy treatments, and, to a lesser degree, involving family members.
- Nurses played a key role in co-ordinating care, ensuring referrals were made to other team members and providing information.
- As part of the co-ordinating role, nurses acted as a 'buffer' between dissatisfied clients and carers and 'the system'. They tried to diffuse tensions and complaints. This was a tiring and unfulfilling part of nursing work.
- Qualified nurses delegated large amounts of physical care and hence integration of therapy to support workers or auxiliaries. However, support workers received limited amounts of instruction and guidance. In consequence, the extent to which rehabilitation principles and care plans were adhered to varied widely.
- Members of the multiprofessional team were reliant on nurses carrying-on with their treatment plans, integrating them into everyday activities and providing feedback on progress. Without this, therapy staff felt that client progress would be hindered.
- Many members of the multiprofessional team saw the nurse's ability to build a strong relationship with the client as a unique contribution.

This chapter looks at the contribution of the nurse to meeting clients' rehabilitation needs. The chapter is divided into two parts. The first part explores the way in which the nurse identifies the needs of the client and carer through the process of assessment. The second part examines how the nurse goes about meeting these needs.

11.1 Identifying the needs of the client and carer

This section considers assessment and clients' rehabilitation goals.

11.1.1 Assessment

Nurses assessed clients on admission to hospital and continued assessment throughout the client's stay. Within the community setting, district nurses and nurses in the rehabilitation team made an initial assessment on which they based their input to that client's care.

Nurses described their assessment as involving:

- *'Monitoring signs, symptoms and complications'*
- *'Looking at the options, the best options'* (Sister)
- *'Doing your full assessment over time, build up information'* (Staff nurse)
- *'Getting to know the client and monitoring the client in all aspects'* (Staff nurse)
- *'Find[ing] out what they [the client] want from us'* (Staff nurse)
- Assessing medical status and whether the client is fit for therapy and to take corrective steps when there is no therapist available to liaise with.

Where nurses were responsible for assessing clients' suitability for rehabilitation, other aspects, such as ensuring that clients fitted the admission criteria, were important. Often, nurses were responsible for assessment alongside therapy staff and used a mixture of intuition and more formal protocols. One staff nurse described the process as follows:

> *'It's to assess the client to see if you think they would qualify to come onto the rehab. ward to participate in the rehabilitation process. Obviously, you're looking at the type of client, the age, the condition of the client, and obviously motivation and being willing to get back on their feet and get back into the community as well. And that is a really difficult skill because you could end up with clients you can't rehabilitate and would end up having to go in nursing homes or rest homes. And you have to watch for bed blocking as well because there's lots of clients that want to come for rehabilitation, but as you know, we've only got 12 rehabilitation beds, so they'd soon get full with clients that weren't suitable for rehabilitation.'* (Staff nurse)

In the community, nurses on a stroke rehabilitation team performed the initial assessment. The nurse was able to identify specific nursing needs and problems requiring the input of other team members, who would then be informed. Once admitted to a ward, accepted by district nurses or a community rehabilitation team, a nursing plan of care was devised and information relayed to other members of the multiprofessional team as necessary.

Whatever the location, assessing a client was a process for which sufficient time was required: *'You need time to sit down with a client and find out what they want'* (Sister). The emphasis lay on finding out what clients wanted and being holistic.

> *'We look at it holistically. We don't just say "Right, we're gonna see them walk" like the physio does, and the OT is "Make sure they go home" – we look at it holistically.'* (Staff nurse)

'Being holistic' appeared to mean looking at the client globally, rather than focusing on specific aspects of functioning or need, such as mobility or swallowing. Nurses implied that their assessment was broader in nature. This contrasts to the therapists' assessment, which was perceived to be more tightly focused and restricted. Nurses also tried to draw links between actual and potential problems that might result for clients and their activities of living. For example, nurses linked poor fluid intake to urinary tract infection, to incontinence and reduced mobility. Other examples included linking a lack of social interaction or sleep to depression, reduced motivation and independence.

The nurse assessment was also described as focusing on what the client's previous abilities had been, as a baseline against which to measure potential for improvement.

> *'When you do the initial assessment … you pick a lot of things up from that. What the client was actually doing before their illness, so you know that you're not gonna get this client running up and down the ward if before they had their illness they were only sort of walking from the furniture to furniture. There's a lot of things really that you observe … like, social interaction between the clients. Because you know that if a client is just sat in one spot all day, not speaking to one another, that that can lead to depression. You also need to observe that they've had enough nutrition … If their general condition deteriorates, then you're not gonna get them back to the normal.'* (Staff nurse)

The nurses had to observe the client over time and seek out more detailed information from family members. On the basis of their assessment, nurses were then able to ascertain whether input from other team members would be necessary.

'When we do our assessment, the nursing assessment with the client at the bedside ... If the client can't tell us himself, the relatives usually come with the information that you need ... On our detailed assessment we will pick up whether you know they're going to need some ... Most strokes would always be seen by the OT and the physio ... I don't think I've ever nursed one that hasn't really.' (Staff nurse)

In the hospital setting, nurses also monitored and assessed clients informally on an ongoing day-to-day basis. Through their ongoing assessment, nurses were then able to feed information back to other team members: *'tell them [therapists] what clients have been like on a day-to-day basis'* (Staff nurse). The insights gained from their ongoing monitoring also enabled nurses to at least partially direct the input of other team members.

'We get to the client first and I say to the OT, "Can you do some dressing practice with Florence, because she's not very good with buttons".'
(Staff nurse, rehabilitation ward)

The ongoing nature of nurses' assessment also meant that they were able to pick up on new problems that clients may experience and initiate prompt intervention. Within the community, informal assessments occurred on every visit and treatment and the plan of care could be then adapted as needed.

On discharge from hospital, liaison nurses (usually district nurses) assessed for nursing care, whether to arrange for district nursing care at home or to decide if clients needed nursing or residential home care. Referrals to other team members, such as community physiotherapy, could also be made at this time. When clients were to be admitted to nursing or residential homes, a nurse from the home sometimes came and visited the client on the ward to carry out an assessment.

In summary, nurses gained information for their assessment from a variety of sources:

- the client
- the client's family or friends
- the transfer letter
- the medical record
- from talking to other members of the multiprofessional team
- observing the client
- knowing about the client's underlying medical condition.

The assessment occurred at many different stages of the clients' rehabilitative career, both in a formal and informal sense. Table 11.1 provides an indication of the main areas of nursing assessment.

Area of assessment	Examples of methods of assessment
Any new problems arising	
Assess for suitability for rehabilitation no formal tools used	Social, activities of living, mood, comprehension –
Assessing whether the client will manage at home or whether should go to nursing or residential home (district nurse liaison)	Building up a picture of the client over time and talk to other team members such as OT
Communication	Talking to clients and observing them
Dependency scores	Northwick Park
Elimination – bowels and bladder monitoring urine, stool	Charting elimination patterns, history taking,
Family coping they're feeling	How family are doing, what they're saying, how
Functional assessment	See what clients can do for themselves Sometimes the Barthel Index or Functional Independence Measure
Medication	Monitor effectiveness of medication, observe for side effects
Mobility, moving and handling	Observation of client, trying them out, see what they can do
Nutrition	Sometimes use a screening tool plus weight, blood values, observation of eating patterns
Pain	Subjective, non-verbal and verbal communication, family, vital signs
Pressure area care and skin	Waterlow, moving and handling, observing
Psychological	Observation of client, listening to and talking to client, family, *'he doesn't seem to comprehend what we're saying to him so we're going to refer him to the psychologist'*
Sleep	Client report and observation
Social background (housing, adaptations, stairs), family support, social care package needed	Talk to client and family, other members of the team
Swallowing	Ask client about swallowing – any drooling, coughing, rudimentary swallow assessment – whether client can cope with soft diet, whether they should be 'nil by mouth'
Vital signs and medical state	As everywhere
Wounds	Pressure sore scales, measurement, monitoring by sight

Table 11.1: Areas of nursing assessment

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Other members of the multiprofessional team saw nurses as playing an important role in the initial identification of the client's problems early on in their rehabilitative career and referral on to other members of the multiprofessional team. They provided a continuous form of assessment, through the implicit 24-hour presence/contact with the client. At least in principle, this allowed nurses to observe and monitor clients' progress and pick up on changes in their condition or any new problems. Other team members noted that nurses working in specialist areas were thus able to make useful suggestions about therapy and care or adapt these depending on the client's status.

11.1.2 Clients' rehabilitation goals

Arising from the nursing assessment was the plan of care. It involved setting goals for the clients' rehabilitation. This was usually based on an 'activities of living' model and drew on the assessment of all team members. While this was largely seen as a team activity, including the client and their family, the extent to which this occurred varied between settings. It depended on the team mix for that area. Where client notes were shared between the whole team, clients' rehabilitation goals were clear. Where different team members had their own notes, clients' rehabilitative goals varied for different professionals and were written in different places.

In designated rehabilitation areas and the community rehabilitation team, goals for rehabilitation were carefully planned. The emphasis was on breaking down clients' ideal goals (such as to walk again) into smaller more achievable goals that the client could hopefully fulfil in a shorter time.

> *'It's very much client led. They are asked what they want out of their rehab., where they see their future, and then we work out a plan together to try and reach those aims ... with regular review dates ... I mean most people would say they'd like to walk again, but we don't put that down initially as a goal, because often it's too far in front ... So we will explain to them about breaking it down into smaller steps, like initially being able to transfer between people, or one person, moving on to transferring on their own. And then moving onto the walking as each goal is met ... And it doesn't seem so impossible to them, you know ... They can tick off and say, "Right, I've done that, I can do something else now".'* (Staff nurse)

11.1.3 Summary

Nurses fulfilled an important role in assessing needs over a broad range of areas, both early on in the client's rehabilitative career and on an ongoing basis. Nurses identified immediate nursing needs, potential problems and the most appropriate members of the multiprofessional team to refer on to. They were also able to monitor clients' progress, feeding back vital information to other team members.

On the basis of the nursing assessment and assessments performed by the rest of the team, a plan of care and rehabilitation goals could be devised. This involved breaking down longer-term goals into smaller steps which could be achieved in the shorter term. Goal setting ideally involved the whole team, client and carer, although this was difficult to implement.

11.2 The actual role of the nurse

The nurse's role was identified as having a wide variety of aspects (Table 11.2):

- co-ordination
- physical care
- therapy integration and therapy carry-on
- clinical nursing care

- emotional care
- supporting and involving the family.

Each of these roles will be explored in detail from the perspective of nurses and, where appropriate, from the perspective of other team members and users and carers.

Clients and carers	Multiprofessional team	Nurses
Listen to what I want, understand my needs, see how I am	Assess needs Inform goal setting	**Assess** needs **Goal** setting
Always there Someone to *'point you in the right direction'* and 'get' other people involved	Central team member There 24 hours a day and seven days a week The diplomats Provide information on client's progress towards rehabilitation goals – team members can then tailor treatment plan to client	**Team co-ordinator** Referral, liaison, discharge planning, delegation (especially to support workers and students) Buffer to the system Managerial responsibilities (ensure ward clean, safe, staffed, and equipment working) Offer information, advice to team, ask for specific input from team
Help you with everything Physical help valued – when clients perceive that nurses are not providing enough help, seen as uncaring Keep you safe	Physical care important, but *'doing role'* seen to dominate approach at expense of 'rehabilitating'	**Physical care** but try to 'stand back' too – not always possible due to time pressure and client expectations
Encouraging, supportive	Integrate therapy into activities of living and carry on therapy treatment Monitor clients' ability Feedback to the team	**Therapy integration** Stand back, encourage rehabilitation, build therapy into activities of living **Therapy carry-on** Do specific treatments such as thermal stimulation, passive exercises, moving and handling
Medicines, dressing wounds	Possess medical knowledge	**Clinical nursing care**
Caring and helpful Cheer you up, can get to know the nurses, someone to talk to	Provide psychological care and possess good communication skills Know the client and carer	**Emotional care** Listen to fears and worries, build up a relationship with client and carer Advocate for client and carer
Teach you, explain to you	Client education and explanation, health promotion	**Involve family members** Information source for client and carer – health promotion, client education

Table 11.2: The actual role of the nurse

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In all fieldwork settings the nurse acted as team co-ordinator, though to varying degrees. Nurses saw themselves as the 'hub' of the team, a central point for other disciplines, *'other disciplines revolve around us'* (Staff nurse). It was seen as a unique role which was essential to ensuring effective client care:

> *'The nurse's role is unique in the fact that we're here seven days a week and 24 hours a day, we're the team leader ... If we weren't here, it would fall apart totally.'* (Sister)

The co-ordinating role involved a number of different aspects including:

- directing the input of other team members in relation to specific clients
- referring to other team members
- liaising between different team members and passing on information
- gathering information, monitoring clients and acting as a source of information
- sorting out problems
- planning for discharge.

Directing the input of other team members

Nurses were observed to direct the input of other team members. This consisted of nurses asking team members to spend time with certain clients in order to concentrate on particular aspects of treatment:

> *'It's up to me to think, let's do this with a client.'* (Staff nurse)

> *'To be able to say to the therapist, "Please this morning can you hold off for a while because I don't think they're medically well".'* (Sister)

Nurses saw themselves as being responsible for ensuring that treatment and care moved forward. Many examples were observed, including:

- The nurse asked the OT to work on washing and dressing with one client, to arrange a staged discharge for another, and asked the physiotherapist to work on transfers.
- In the specialist stroke unit, the nurse asked the physiotherapist to arrange a time to teach the daughter of a client how to do a hoist transfer.
- The nurse rang the dietitian to ask her to draw up a naso-gastric feeding programme.
- The nurse asked the doctor to come over and alter some medication prescriptions.
- The speech and language therapist was contacted to assess a client and come to the team meeting.
- The nurse asked the speech and language therapist to come back later on one occasion as the client was very tired and the nurse felt he would fail the swallowing assessment.
- The physiotherapist was asked to ring social services to cancel meal cover for a cancelled home visit.
- The nurses told the auxiliary nurses and support workers which clients to look after, and nominated one person to ensure another client received a drink every hour.

In other cases, nurses 'pushed' for further therapy input for clients whom therapy staff felt had plateaued. Where the nursing staff disagreed with the therapists' decision to phase out therapy, it became almost *'a battle'* of wills, where nurses tried to persuade the therapy staff to resume further contact with the client. In one scenario, the nurses had decided to start the client with a zimmer frame as members of therapy staff were no longer involved. The skills required for this role were described by one staff nurse as *'managerial and delegating'* ones.

Nurses referred to whomever was deemed necessary to the clients' care. Sometimes, nurses had to have referrals authorised by a medical staff member (for example, for speech and language therapy) which caused delays in treatment for the client and frustration for the nurse. Referrals were commonly made to the OT, physiotherapist, speech and language therapist, dietitian, psychologist, SW and community nurses and other specialist nurses (for example, the tissue viability nurse). On other occasions, referrals were made to GPs (where clients or carers were seen as not coping), the community psychiatric nurse, audiology and podiatry.

Liaising between team members and passing on information

Liaising between team members and passing on information was a role that arose from the nurse's constant presence on the ward in the hospital setting. For example, at ward rounds, consultants would ask nurses to ask the OT to arrange a home visit, or to contact the speech and language therapist to chase up a communication board for a dysphasic client. Nurses also contacted SWs to arrange a case conference and organised meetings between family members and medical staff. Nurses passed information on to the district nurse liaison or discharge co-ordinator in order to ensure the involvement of the relevant practitioners.

When other team members wished to inquire about certain clients, ringing the ward and speaking to nurses was often the first port of call. For example, the SW wanted to find out how a client was progressing towards discharge and rang the ward. The nurse explained that the client had returned from a home visit that had not been entirely successful and further adaptations to the house were required. The nurse recommended that the SW spoke directly to the OT to find out about the type of stair lift required, and passed on the telephone number.

Nurses could also liaise between the family and other members of the multiprofessional team. They were a more easily accessed resource. Indeed on numerous occasions, clients' relatives sought out a nurse about a query about occupational therapy or speech and language therapy as the relevant professional was not available.

Gathering information, monitoring clients and acting as a source of information

Nurses were seen to gather information in relation to clients from a variety of sources:

- the medical record
- the initial and ongoing nursing assessment
- the clients themselves: asking how clients were feeling in themselves and in relation to treatment
- the auxiliary or support worker
- observing the client: medical condition, progress with therapy goals and activities of daily living
- from other team members such as the physiotherapist and OT: ringing up or speaking in person and asking how treatment went, how the home visit went, asking about future treatment plans, asking about plans for discharge
- from multiprofessional team hand-overs and case conferences
- finding out more information and talking to other people: for example, contacting the mental health team about a client's mood or ringing social services to find out about eligibility for financial help.

In this way, nurses were able to build up an overall picture of the client. This included:

- their medical and social history – *'the client lived in warden-controlled flat'*

- help required with activities of daily living – *'needs help with bottom half'*
- mood – *'he's been really down since he got the information about the nursing home'*
- cognitive – *'he's on a different planet … he's had me ringing 'round for his wife. She's been dead seven years'*
- how the family is feeling – *'his wife's upset … she feels like she's been pushed into a decision she doesn't want to make … she wants to come in early and see what we're doing'; 'his daughter is really worried that he's so confused'*
- medication – changes suggested, assessing whether the analgesia was working or not
- any procedures, such as blood glucose or X-ray
- new medical problems arising – *'she's not peed [passed urine] – I'll get the doctor to assess her'*
- all nursing matters, including clinical activities, referrals made/to be made, cases conferences to be arranged, treatments (*'wear splints at night'*), etc.

Nurses possessed a wide range of information in relation to the client, their family and treatment and progress. Armed with this information, nurses were able to monitor the client's progress. Nurses observed progress medically, emotionally and towards rehabilitation goals:

> *'I washed him this morning. He's managing to shave himself but he put his pyjamas on back to front.'*

Nurses handed on this information to each other at the shift hand-over. They commented on all 'clinical nursing areas', medical condition, physical care required, progress towards rehabilitation goals, discharge arrangements, information to pass on to other health care professionals and what other team members were doing. With this, nurses were able to act as a knowledgeable source of up-to-date information for other health care professionals and team members.

Information was shared with other team members either informally or at team hand-overs. By virtue of their permanent base on the ward and links with other staff and services, nurses acted as an actual and potential source of information for other team members and family members. Typically, nurses would answer many questions and queries from a constant stream of different people. This role was very time consuming, but not always recognised for its complexity.

Sorting out problems

Nurses were seen to sort out a multitude of miscellaneous issues. These included cancelling meals on wheels, booking ambulances, ringing receiving wards, liaising with bed managers about client transfers, arranging for investigations to be done, ordering special mattresses, answering the telephone, and finding out results of procedures. Inevitably, work such as this was often more time consuming than nurses desired, with several calls often having to be made to clarify a single issue. This was a cause of frustration as work such as this was squeezed in between providing client care and managing the work of other members of staff.

In addition, 'sorting out' activities could be uncomfortable. Nurses frequently acted as a 'buffer' between dissatisfied service users, their families and the hospital systems. Using diplomacy skills, nurses tried to diffuse tensions and deal with general concerns and complaints. The management aspect of the ward co-ordination role would also entail liaison with other departments such as security, health and safety and outside organisations such as nursing agencies.

As part of their co-ordinating role, nurses played a large part in discharge planning. In some rehabilitation areas, nurses were keen to prompt discharge planning meetings to move clients care onwards. Nurses also encouraged therapy staff to work towards discharge. For example, they might ask the OT to do kitchen assessments and home visits or the physiotherapist to work on mobility or the 'stairs'. Nurses were typically involved in liaising with the SW, assisting the OT with discharge forms and contacting district nurses where necessary. Nurses also tried to find out about the wishes of family members, their home circumstances, transport needs, and ordered discharge drugs.

Other members of the multiprofessional team saw nurses as a 'vital source' of information, enabling team members to fulfil their roles:

> *'We need information from the nurses ... We rely on their information ... We wouldn't be able to do half of what we do without them.'*
> (Speech and language therapist)

Nurses were viewed as being the vital link between the client and the team and between team members:

> *'They are a go between, a giver of information, they retain that information, they liaise between families and quite often they will liaise between myself and other disciplines because they see the OT more than I do ... They give me information relevant to that family, past history, what they know of the brother ... the wife, that helps give me a picture.'* (SW)

They were also seen as the person who was best placed to know the 'ins and outs' of the client's total care and to liaise with other members of staff:

> *'They [nurses] know the clients' needs more than I do, because they have already formed a relationship ...'* (SW)

These views were echoed by carers. They noted the importance of the nurse as someone who could provide information and direction. As Mrs Red's daughter said of the nurses on the rehabilitation ward: *'I've found them [the nurses] excellent in putting me in the right direction'.*

11.2.2 Physical care

Providing physical care was a vitally important part of meeting client's needs. It was often described as *'traditional nursing ... basic nursing care ... overall care'* (Staff nurse). It encompassed a range of activities typically expected of a 'caregiver', all of which are related to 'the body'. These included:

- assisting clients in meeting their personal hygiene needs
- helping clients to dress themselves
- helping clients to meet their elimination needs
- assisting clients to transfer from bed to chair, walk, or sit up in bed
- providing pressure area relief
- giving out meals
- feeding clients unable to meet their nutritional needs
- answering buzzers
- mouth care
- making people comfortable.

This 'physical care' role is closely linked to, although separate from, the carry-on and therapy integration role (for example, in relation to movement and positioning) and more specific aspects of clinical nursing work (for example, in relation to providing pressure area relief or continence assessment). Each of these is described in subsequent sections.

Physical care was a role for both qualified and unqualified nurses. However, it was often the qualified nurse who directed the carrying out of physical care, rather than providing hands-on help. For example, she assessed the degree to which clients required physical help and how these needs should be met. At the beginning of the shift, she would delegate which client would be cared for by which nursing auxiliary. The qualified nurse would sometimes give directions as to how the client should be assisted, for example, directing the auxiliary to give the client a bowl to wash in or to offer a bath, if more appropriate. There were slight exceptions to this in the two more specialist rehabilitation areas. Here, qualified nursing staff seemed to provide roughly the same amount of hands-on care as nursing auxiliaries.

On all wards, and in the community setting to varying levels, nurses attempted to promote independence and encourage rehabilitation during the process of providing physical care. Through a 'hands-off approach' and by 'standing back' where possible, nurses tried to give clients the opportunity to do things for themselves while still providing high quality physical care.

The provision of physical care was an area of the nurse's contribution often commented on by clients. On the occasions where clients did not mention this nursing role, it was as if it was taken as 'a given' that nurses helped with physical needs, and so need not be mentioned. Clients valued nurses' help with using the toilet, washing, eating and drinking:

> *'... the daily help ... with things I thought I'd never manage, within the limits of their time of course.'* (Mrs Pink)

> *'They are always getting you up to the commode, or sat up in bed', 'they're all food', 'do all the dirty jobs', 'looks after you to see if you want to get into bed'* (Mrs Red)

This role was also perceived by other members of the multiprofessional team. Indeed, they saw providing physical care as an important and unique part of the nurse's contribution. Nurses, as the main day-to-day carers, were seen as the staff most able to educate relatives who would care for clients on discharge. On one occasion, a physiotherapist asked a relative to *'come and spend the day with the nurses'* so that she could learn what caring for her husband would involve. At the same time, other team members were concerned that this nursing activity was more a 'doing for' and 'helping' as opposed to contributing to rehabilitation: *'They're seeing it as a medical ward really, rather than a rehabilitation ward with each patient's individual needs'* (Physiotherapist). Some felt that this role was restricting the nurse, and standing in the way of a more appropriate and extended remit to include integrating therapy and adopting a more therapeutic, rehabilitative approach.

11.2.3 Therapy integration and therapy carry-on

Nurses working in specialist hospital rehabilitation settings in particular (although not exclusively) tried to integrate therapy into clients' activities of living and to carry on specific treatments prescribed by therapists. *Therapy integration* involved the nurse taking a rehabilitative approach to client care, giving clients time and encouragement, standing back and incorporating therapy into their activities of living. Examples included encouraging and assisting the client to do transfers the way the therapists recommended when using the toilet or going to the dining table. *Therapy carry-on* had a narrower focus. It involved doing the therapy exercises with clients, such as supervising swallowing exercises or passive exercises. Both therapy integration and carry-on required the nurse to adopt the philosophy and practice of rehabilitation, and additional skills and knowledge.

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Areas of overlap between the work of the therapist and that of the nurse were seen as essential to maximise the effectiveness of therapy and to meet the client's rehabilitation needs. Many nurses were concerned to carry on and incorporate the therapeutic strategies and approaches initiated by other team members during the process of providing physical nursing care. For example:

> *'Some of the roles of the other therapists the nurses have got integrated into their role ... I would say the nurse's role is to continue rehab. ... The nurses have got the skills to continue their role when they're not there ... we don't want to be physios, we don't want to be OTs, it's just we've got that skill and we're the ones who are here 24 hours a day, seven days a week.'*
> (Staff nurse)

Continuing rehabilitation was seen as essential to maximising the client's recovery, with the nurse having an important part to play. The nurse was following and/or adapting the plan of care devised by other team members, and was essential due to the time-limited contact which the therapists had with a client. In response to a question, *'What parts of your role are rehabilitative?'*, a staff nurse replied:

> *'Well, it's like when they have the personal hygiene, it's to encourage them to do whatever the OT has asked them to do. Because they have an OT assessment and then the OT will write down in the nursing notes just what this patient has done or what this patient is able to do. So we look at that and we would encourage a patient to do that. So, we have to carry on with the instructions that they have given us. Also, mobility, we have to carry on mobilising them, because like the OT or physio might only be with them for 20 minutes in a day, so it's your responsibility then to carry on with that throughout the day.'* (Staff nurse)

Thus, nurses attempted to *'informally carry on'* to maintain continuity of care. This was particularly so at the weekends, so that clients were not *'back to square one on Monday'* (Staff nurse, rehabilitation ward).

> *'She lets us know what we can do to help ... reinforce what she is doing.'*
> (Staff nurse)

> *'[We] hold the fort over the weekend ... try to carry on what they've been doing ... we try to work on mobility if we have time.'* (Staff nurse)

Nurses did not on the whole see it as part of their role to plan care. This fell within the domain of the therapists' work:

> *'We wouldn't actually plan their physio. A physio would plan how they want us to walk and what they want us to do and we would carry it out.'*
> (Staff nurse)

The integration of therapy into activities of living required the nurse to temper the traditional nursing care approach, from 'doing for' to 'helping with' and providing encouragement for the client to learn old skills anew.

> **Auxiliary:** *'Where's your brush, K?'* **K:** *'In that bag ...'* (pause)
> **Auxiliary:** *'Do you want to have a look for it?'* The support worker pulled the table up to the client and put her bag on the table for her to look in. K got the brush out. K motioned to the auxiliary to brush her hair but the auxiliary said: *'No, I want you to try it'*. She left K for a minute to do it while she tidied up. K managed to brush one side of her hair and then the auxiliary finished off then took her for a cup of tea.

Many such instances were observed of nurses and support workers being able to and actually working in a 'rehabilitative' manner, rather than just meeting clients' physical needs. Notices above clients' beds enabled this too. For example, there were usually mobilisation charts, positioning charts, transferring charts, instructions for speech and language therapy exercises, and swallowing and nutritional requirements. In some units, care plans included instructions as to how best to carry out washing and dressing and walking so that nurses followed these prescriptions.

Other team members relied on the nurse to indicate what they had done in contributing to meeting rehabilitation needs:

> *'If patients progress over the weekend, you must tell us so we can update it [the mobility chart above the bed].'* (Physiotherapist to staff nurse)

Nurses formed an integral part of an information feedback loop to therapy staff, providing insights into how clients were progressing or coping with treatments, and how well they were moving towards their rehabilitation goals. Nurses also provided direction to the involvement of other team members, in areas which they felt needed further attention:

> *'I've had a word with the OT to concentrate on him this week, his washing.'* (Staff nurse)

This allowed therapy staff members to develop their plan of care to the specific needs of the client.

Other team members perceived the nurse and support worker as the prime person to carry on from the time-limited therapy sessions provided by therapy staff. It was seen as *'important for them [the nurses] to understand what we [therapists] do'* (Physiotherapist). Further:

> *'The whole point of a rehab. ward is that we are there to assess and show people what to do and then we say to the nurses, "Well, can you encourage this lady to toilet herself at night?" And I give them guidelines of what to do and they follow that. They are very supportive.'* (OT)

There was an expectation that nurses and support workers would provide the reinforcement and continuity to build on discrete therapy sessions. Thus, the physiotherapist asks the client, *'Have you done a lot of walking with the nurses?'*

Finally, the desire and expectation of nurses to provide carry-on and integrate therapy stemmed from the fact that nurses provided 24-hour cover. Members of the therapy staff recognised the insufficiency of their contact time:

> *'Ideally we should be doing washing and dressing with each client from day one, but we just don't have the manpower.'*

The clients' perceptions of the nurse's role in carry-on and therapy integration were difficult to identify. Their experiences fell into three main areas:

- the nurse protected them from further harm

  Clients often mentioned the way in which nurses protected them from further harm or danger in the process of providing physical care and assistance. This was particularly noticeable for mobility:

  > *'She never let me fall [when walking].'* (Mr Green)

- distinct role demarcations between therapists and nurses

  Other clients were quite aware of the different roles of the various health care professionals. They saw distinct role demarcations and issues of knowledge and skill:

  > *'It was better with some nurses than others. As long as they pay attention to the physio and had been trained by the physio, then it was OK... But*

some nurses weren't interested ... don't listen ... There seems to be a fight with the physios, you know, it's "Don't do that 'cos the physios doing it".' (Mr Charcoal)

Typically, although nurses helped the client to walk to the toilet, this was not seen as physiotherapy. One carer explained that she felt the nurses did not see therapy as part of their jobs, but began to help once the physiotherapist was involved:

'I suppose they [the nurses] did not think it was their job, but once she was walking [with the physiotherapist], then they'd help her.' (Mr Blue)

Although nurses identified problems requiring therapy, once the initial referrals were made to therapists, this area of care was perceived as *'nothing to do with them'* (Mrs Orange).

- making a contribution to therapy and rehabilitation

Other clients saw nurses as contributing to therapy and rehabilitation, in terms of following on from the work of other team members and providing vital encouragement. This was notable in relation to mobility:

'They [the nurses] got me to stand up which was one of my problems, because I couldn't stand up without shaking. So, yes, they did provide encouragement, but I couldn't get walking until the physios had a go at me ... The nurses got me to move around, take me to have a wash, taking little steps, under their guidance.' (Mrs Pink)

11.2.4 Clinical nursing care

In both hospital and community settings, nurses carried out a wide range of clinical nursing activities even where clients admitted were classified as medically stable. These activities were similar to those carried out by nurses in many areas of health care. Examples included:

- cannulation and venepuncture
- monitoring vital signs
- medication administration and monitoring effectiveness and incidence of side effects
- initiating and implementing changes to medication
- collecting specimens, e.g. sputum, urine, faecal, wound swabs
- carrying out MRSA (methicillin resistant staphylococcus aureus) infection screens
- monitoring lung function and providing chest care
- catheter management – suprapubic, urethral catheters
- continence management – urinary and faecal – suppositories, enemas
- wound care – dressing wounds, assessing healing
- enteral and parenteral nutrition
- diabetes management
- organising investigations and preparing clients for them.

Link nurses provided further clinical expertise for some of these areas. As well as carrying out procedural work, nurses also performed an ongoing assessment role in relation to clients' medical status. Nurses were constantly on the look out for any deterioration in the client's health which might affect their rehabilitation.

Members of the multiprofessional team, clients and carers recognised and valued the nurse's specialist skills in this area of client care. However, because this area of care was the expected input of the nurse, it was an almost taken-for-granted contribution.

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The emotional state of clients and their families was commonly reported and discussed in nursing and multiprofessional hand-overs (*'she's very depressed, she needs a lot of encouragement'*). Through the continuous presence of the nursing team, important insights into clients' moods, family relationships, health status, desires, needs, fears and anxieties were gained. Indeed, psychological and emotional care was commonly viewed as an area of nursing expertise and a unique nursing contribution. For example, typical comments included:

> *'People will tell nurses things that they would not tell to a physio or the OT.'* (Staff nurse)

> *'That's a role that nurses are far better equipped to take on than anybody else.'* (Physiotherapist)

The elements of psychological and emotional care are layered and interconnected but can be viewed within a number of headings:

- building a relationship
- providing individualised care
- being encouraging and reassuring
- referring on to a specialist.

Building a relationship

Nurses valued the opportunity they had to sit down with and get to know clients and their families. Indeed, building a relationship and helping the client to adapt to their new circumstances was a very rewarding part of the job:

> *'... it's nice to be able to actually see patients' improvement. You see them come here quite poorly or quite disabled and you work through with them getting them back integrated into normal life; and if not, you look at the other options and the best options [for] that patient. But the main reason I stay in rehab. is to see people get integrated back into normal life and also to build a relationship up with the patient.'* (Staff nurse)

Nurses used their well-developed interpersonal skills to build their relationship with the client and family by *'chatting, working it through, discussing, spending time with the client'* and *'creating a family-like atmosphere'*. Indeed, joking, humour and banter were significant, and nurses talked about everyday issues such as football, fashion or families. Whether this was a conscious effort on the part of the nurses or not, this process served to cheer clients and maintain their connection with the realities of life outside of their illness. Through this contact and the potentially supportive relationship engendered, nurses were able to give clients the opportunity to talk about other things, if they wished. Many believed that nurses had a greater sense of responsibility to the emotional care of clients and their families than other health care professionals did:

> *'I think it's the relationship they [nurses] build up with people ... The physios and the OTs feel that they're here to do a job, you know. They take the patient for half an hour's treatment and that's the end of their relationship with that patient until tomorrow, or two days after, whereas nurses are in the forefront all the time and you've got that relationship with both the patients and the relatives. Physios and OTs might not ever see the relatives the whole time ...'* (Staff nurse)

Clients often mentioned that nurses were approachable or *'just normal girls'*. This was seen as a favourable attribute which meant that clients and carers could *'... get a laugh out*

of them' (Mr Cream) and nurses were able to *'keep everyone cheered up'* (Mrs Orange), or *'keep me sane'*.

Nurses who sat down with clients and carers were often mentioned in client interviews. Mrs Brown said that one particular nurse *'was brilliant'* with a good attitude, good practical skills, worked hard, always stayed late, was dedicated, fussed over her, and made sure she was moved into the main ward from a side room where she was very frightened. Mrs Brown was terrified of being left alone with her tracheotomy as she had suffered a serious blockage while in a side room. This particular nurse was seen to understand and recognise her needs and always *'stopped for a little chat and said hello and asked how she was'*.

For Mrs Blue, someone to talk to and listen to her was vitally important for her rehabilitation. Her husband said:

> *'In the [rehabilitation] ward they had time to speak to her and it brought her out of herself... It gave her much more confidence to try some of the things the physio had wanted her to do ... To try and walk herself, try and dress herself.'*

Mrs Blue said, *'If I was blue, they stayed and talked to me'*. Looking back to her stay on the acute ward, Mrs Blue said, *'I don't think I spoke to anyone in all the time I was there'*, and her husband added:

> *'It is important in rehab. that someone can come and talk to her ... that's important because she felt so alone ... although she was in a ward of 30–40 other patients, she was alone.'*

A meaningful relationship with a nurse could make all the difference to the client's experience of rehabilitation. It was particularly important when clients needed ongoing input. For Mrs. Pink's daughter, this was a process that took time due to previous dissatisfying experiences with hospital staff. A relationship with the district nurse that began with mistrust and frustration eventually became a source of support. She subsequently described her as a *'tower of strength'* when the family was planning for their mother to come home. For other clients, nurses as a constant presence either on the hospital ward or as regular visitors at home could be very reassuring. Mr Navy's son said of the nurses: *'They were very helpful... helping day by day to get better ... he got attached to them'*.

Providing individualised care

Providing individualised care was closely linked to or an integral part of this emotional, caring role. It related to 'knowing about' the client, as a person, their specific needs, and then trying to act on that information while still providing nursing care. Small actions showed clients that nurses considered them as individuals and cared about them. For example, on one acute medical ward, a client was left to sleep through until after 8a.m., although all other clients had awoken at around 7a.m. and had begun to get up. The nurse had also saved the client's breakfast. The nurse knew that the client would be receiving physiotherapy around 11a.m., and if the client got up too early, she would struggle with the physiotherapy. Other examples included:

- offering reassurance to a client that it was normal to feel exhausted after a stroke
- finding out how a client was feeling after a home visit
- problem solving with a client to maintain dignity – the client was enabled to wash her own groin while lying down as she could not do it herself when standing as she had to hold on to the nurse
- knowing when the client is in pain even when they would not admit it
- asking a client if he is getting used to having his daughter help with activities of daily living

- moving a client's bed away from a depressed patient as the nurse felt it was bringing her down
- being loving and caring – using physical contact to comfort and reassure, such as crouching beside a bed or giving a hug.

There were many incidences where nurses demonstrated that they had begun to *'get to know'* their clients. They showed this to the client, by serving a hot drink to the client's desired specification, ensuring that a client was able to choose when to have a shower or a bath, or assisting with an activity, such as washing, in the way that was most comfortable for the client. However, this did not always equate to the planned rehabilitative method. Occasionally, when the nurses let the client choose, the choices they made did not always follow the rehabilitative treatment plan devised by other team members.

At the same time individualised care was not always the actual or perceived reality. Clients were often not given choice over simple issues, such as when they would get up in the morning, when they would have a hot drink or snack, how long they would be allowed to drink that drink and when they would have a bath or shower. There was the ward routine:

> *'We get all the patients up, breakfasted, washed, dressed and toileted ...*
> *Then it's the brews, lunches, more toileting and then bed.'*
> (Nursing auxiliary)

There were indeed many potential barriers, particularly in relation to the smooth running of the ward, the structure of the service and the process of providing care.

Clients and carers also highlighted the importance of the nurse's contribution to protecting their emotional wellbeing. The way that the nurse provided physical help or their attitude to the client expressed this psychological and emotional care. Being willing to *'do things for'* and being helpful were seen as desirable nursing attributes.

> *'They're very helpful. Most of all they think about whether I am comfortable or not ... They come and move me.'* (Mr Russet)

Being loving and caring was another way this was expressed. There was also a valued and largely expected nursing attribute. In many cases, the nursing staff was seen to fulfil this expectation.

> *'Everyone of them day and night was really, really kind and very helpful.'*
> (Mrs Orange)

> *'Patience of saints.'* (Mrs Red)

Through a caring attitude, some nurses were able to provide the vital encouragement and confidence that a client would need in order to benefit from the rehabilitation process.

Being encouraging and reassuring

Being encouraging was an overarching component of the nurse's approach to rehabilitation. Offering encouragement (*'you're doing really well'* as a client walks to the toilet with the nurse, or giving the client *'that extra little push'*) and positive feedback were both part of reassuring and promoting a positive attitude. Through verbal prompts, the nurses gently encouraged clients to attempt activities themselves rather than have a nurse carrying out the activity for them. The following observational extract illustrates this type of intervention:

The nurse on the community stroke team had a long-standing relationship with Mrs Yellow and visited her about once a week, in addition to the weekly visits from the OT. The nurse provided a listening ear, encouragement and reassurance for her. In one observation session, the nurse was encouraging Mrs Yellow to go down to the coffee morning which was held in her sheltered accommodation once a week. The nurse was explaining that it would help

if she got to know some of her neighbours and had the opportunity to speak to others, despite her faltering speech. (Community stroke team, Session 2)

This types of encouragement could be very positive for the client's sense of emotional wellbeing, giving them hope within the current situation and showing them the potential for recovery. Indeed, being 'encouraging' was an important attribute that clients described in nurses. By their presence and attitude toward the client some nurses were described as being able to: *'give you a feeling of confidence'* (Mr Russet) or be *'very reassuring'* (Mrs Red).

Referring on to a specialist

When nurses detected a psychological need, they often felt that the client should be referred on to a specialist who could shed further light on the client's psychological needs. However, at times, the nurses did not feel that this was a complete and effective response: *'We refer on to the psychologist and the patient pops a pill'* (Sister).

11.2.6 Supporting and involving the family

Nurses frequently mentioned the importance of involving family members in the client's care. Nurses sought to do this mainly by offering reassurance and information and being available to answer family members' questions:

> *'Relatives are free to chat with the nurses and case conferences can be set up if they want or there is a lot to discuss.'*

They acknowledged that family members needed ongoing support and psychological care:

> *'Their families can be in exactly the same situation ... They are obviously grieving for the person that was, you know, and whilst some get near to how they were but not quite ... I think it's more like an ongoing, listening to people, you know, people's fears, reassuring them, not giving false hope.'* (Staff nurse)

The extent to which family members were coping with the new situation was commonly noted in nursing shift hand-overs. The need for case conferences with family was sometimes raised at this point.

Nurses also provided information to the family. This information provision could relate to the client's progress with rehabilitation, specific treatments (shoulder care, transfers and positioning), the input of other members of team, discharge arrangements, and specific nursing and medical aspects (diabetes, wound care, medication, nutritional needs). The provision of information was sometimes in the form of a teaching role. For example, nurses explained to relatives the importance of letting the client do as much for themselves as possible (for example, telling the wife that she does not need to feed her husband). Nurses also said that sometimes they tried to give information on health promotion to family members, although this was not observed by the researchers.

Clients and carers were encouraged to be involved with goal setting and read client care plans. On occasions, nurses sought to involve family members by encouraging them to help with the client's actual physical care. This was usually if a family member was intending to act as a carer for the client. Typically, family members would help with washing and dressing or learn to transfer and position clients. When home visits were planned, involvement in hands-on care became more pertinent.

Family members had mixed experiences of being involved in their relative's or friend's care. For some carers, nurses were seen as very approachable and supportive and an important source of information.

'The nurses have told me everything and I feel more relaxed and happy about that ... The nurses did give me a list of the things that were going to be done.' (Mrs Red's daughter)

However, for many other carers lack of information and hence involvement in client care was a serious area of unmet need which could cause great levels of anxiety and upset.

From the perspective of other members of the multiprofessional team, nurses were seen as providing a vital link between themselves, the team as a whole, and family members. This was by virtue of their continuous presence and perceived approachability.

11.3 Summary

This chapter demonstrates that the nurse has a wide-ranging contribution to make towards meeting the total physical, emotional and social care needs of the client and carer following a stroke. This can be seen from the perspective of all members of the multiprofessional team as well as the clients and carers. The direct 'hands-on' roles included aspects of specialised clinical tasks as well the range of activities related to more basic 'caregiving'. Rehabilitation skills such as moving and handling are required to 'carry on' and integrate the work of other therapy staff. The co-ordinating role encompasses aspects of organisational management, including the gathering and dissemination of information, discharge planning, referring on and liaising with other members of the multiprofessional team and staff management. Providing emotional care and support was highlighted as important for both clients and carers, and seen as a fundamental part of the role by nurses themselves.

Key points

- Clients and carers identified areas of unmet need, including a lack of 'therapy', information, involvement in decision making, emotional support, and adequate recognition of carer needs. Other areas of concern were experiences of routinised, institutionalised and ageist services.
- Clients suggested staffing shortages and 'burn out' as the main reasons for inadequacies in their care.
- Nurses wanted more time to spend on direct client care, emotional care, social activities, health promotion and to give a greater emphasis to involving the family.
- All members of the multiprofessional team saw considerable benefit in nurses developing extra rehabilitation skills and knowledge to enable therapy integration and therapy carry-on.
- Team working was seen as an area for development. Nurses recognised the need for a consistent skills base throughout the entire multiprofessional team and desired greater recognition of the nursing contribution.
- Nurses wanted greater responsibility for aspects of client assessment, for example, in assessing swallow ability and potential in activities of living. This was seen as a means of meeting gaps in therapy provision and improving client care.
- Responsibility for assessment brought power and esteem. Where boundaries of assessment were blurred, tension could occur within the multiprofessional team.

The previous chapter outlined the areas where the nurse was meeting the needs of the client and carer. Other data identified areas of unmet need, which had a negative effect on the rehabilitative experiences of the client and carer. This is explored in this chapter together with perceptions of the desired role of the nurse.

12.1 Areas of unmet need

Clients and carers identified a number of interconnected areas of unmet needs. These can be grouped into four main areas:

- therapy and physical care
- communication, information and involvement
- emotional and social support
- physical support.

Figure 12.1 provides an overview of these four categories. Each is examined in turn.

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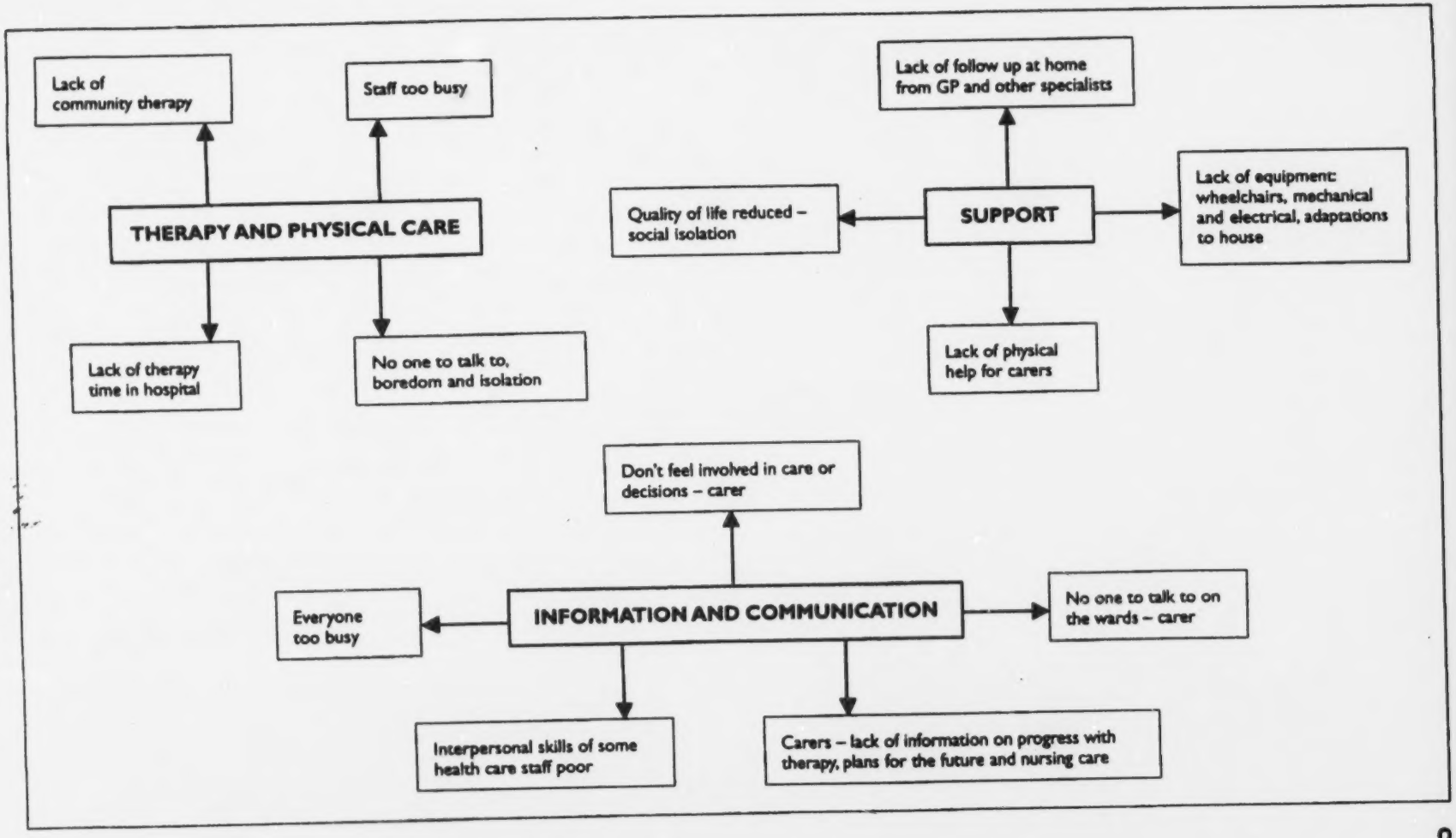
Lack of community therapy
Staff too busy
Lack of follow up at home from GP and other specialists
THERAPY AND PHYSICAL CARE
Quality of life reduced – social isolation
SUPPORT
Lack of equipment: wheelchairs, mechanical and electrical, adaptations to house
Lack of therapy time in hospital
No one to talk to, boredom and isolation
Lack of physical help for carers
Don't feel involved in care or decisions – carer
Everyone too busy
INFORMATION AND COMMUNICATION
No one to talk to on the wards – carer
Interpersonal skills of some health care staff poor
Carers – lack of information on progress with therapy, plans for the future and nursing care

Figure 12.1: Client and carer unmet needs after stroke

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12.1.1 Therapy and physical care

A lack of therapy, individualised care and physical care was identified.

Lack of therapy

Many of the clients interviewed felt aggrieved at the lack of therapy treatment they were offered while in hospital and at home. This was particularly notable for speech and language therapy, and on occasions occupational therapy and physiotherapy.

> *'He's coming [home] in a fortnight ... There's not much speech therapy ... That's one problem ... There's nothing worse than if you want to say something and you can't.'* (Mrs Purple about her husband)

Similarly, Mrs Blue said that speech and language therapy was:

> *'hit and miss ... You'd get two one week and then nothing for three weeks ... In the end she said, "I can't help you because we've got everyone else to see". It made me angry, but what could I do?'*

Clients complained that they spent long periods of time doing very little. This was perceived as precious time that was being wasted when they could be having therapy. This lack of therapy also held them back. For example, although Mr Charcoal had been on the rehabilitation ward, *'None of the physios came to see me for a few weeks which I think set me back'.*

Lack of individualised care

A range of data, from clients, carers, observation and staff interviews supported a sense that rehabilitation was only provided in a limited way. Its prime focus was aimed at promoting improvements in physical functioning, rather than a broader, more holistic approach, enabling clients to adapt to their stroke and incorporate it into their lives.

Two clients illustrate the problems faced. Mr Grey, who was living in his own home, explained that his main desire was to gain confidence and practice at walking outside so that he would be able to go to the shops by himself. However, the community stroke team did not seem to acknowledge this nor follow it up. He commented:

> *'They're only here for about five minutes ... All they said was, "Have you has something to eat?" So I just said, "Yeah" and with that they go ... They seem shocked if you ask them to do anything, they have other people to see.'* (Mr Grey)

Mrs Blue, looking back to her time in hospital, explained that she had wanted to practise simple activities such as making a drink which had now become a major challenge:

> *'There was not enough people, if I wanted to make a drink, they would say to me, "Well yeah, just let me do this and then I'll come back" and they never came back.'*

The observational data reinforced the perception of routinised care, rather than it being tailored to clients' individual needs. For example, Mr Cream's drinks were often snatched away or left to go cold, before anyone had assisted him with any fluids. Mr Grey's need to walk outside, although voiced, was never acted upon. When Mrs Brown first began to feed herself, no one sat with her, even though her food was falling on the floor and going cold and she was clearly distressed and emotional.

Mrs Black's daughters summed the problem up:

> *'It's all too institutionalised isn't it ... there's no personal touch for any one patient whereas since she's been home ... she's got the personal touch because it's family that are doing it for her ... We've tried to get her life back to normal, like bingo, shopping.'*

An ageist and insulting attitude to older clients was also reported. As Mrs White commented in describing the need for nurses to see each person as an individual:

> *'Somebody who can spot the difference in people, who doesn't generalise ... it's the empathy thing ... The nurses think stroke, elderly, ga ga ... Everybody's stroke is different, that is why you have to remember there is a person inside, not a stroke.'*

Similarly, Mrs Black's daughter felt that:

> *'If my mum was 20 years younger, they'd be treating her a lot different to how they're treating her now ... You get to that certain age and they think, "waste of time".'*

Although some carers conceded that overwork had *'burnt out'* the nurses, and others noted that *'the poor girls are frustrated to hell'* with poor staffing, this was distressing for the on-looking carer.

Physical care

Areas of unmet need were also apparent in the area of physical care, itself of central importance to the nursing role. Reflected in the client and carer perceptions was the impact of poor staffing levels. Clients quickly realised and adapted to it, making allowances for the nurses as they attempted to cope with the workload. Clients often had to wait for a nurse to come and help: *'It's usually the auxiliaries or night staff who ignore you and make you wait for the bed pan ... tell you off if you wet the bed ...'* (Mrs White).

Staff appeared to be very rushed and often patients were left unattended for long periods of time. Mr Cream sat by his bed for three and a half hours without any contact with a nurse or auxiliary. He became sore and uncomfortable and asked the researcher to help him lie down. Again, Mrs Brown reported the frustrations of having to wait for the toilet and having finally being brought a commode, then being left on it for 45 minutes behind flimsy curtains.

Clients tempered their frustrations by acknowledging that nurses are very busy:

> *'They do as best they can, they've got a lot of other patients ... they don't always come when you want them to come ... there's other people as well ... If there's more than three people ringing to go to the toilet, you might be first or you might be last.'* (Mr Grey)

Again, Mr Charcoal commented sadly that *'nurses don't have time to do what they should here'.*

12.1.2 Communication, information and involvement

Clients and carers frequently drew attention to the lack of information provided by health care professionals. This was notable in the hospital environment, in acute wards and in specialist and general rehabilitation areas. It was not uncovered in the community setting. Lack of full and complete information often led to strained relations between staff and carers especially. Indeed, carers' faith in staff was diminished by the lack of organisation and communication they perceived between the different team members.

Not being told

Clients did not feel that they were kept well enough informed about their own treatment and progress. As Mr Grey explained while on the rehabilitation ward:

> *'She's actually just told me that I can go to the toilet on me own ... I wish she'd told me that earlier ... I've only got two days left [in hospital] ... because you're sat waiting, waiting, waiting.'*

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Had he known he could go by himself to the toilet without *'the nurses getting upset'* as he had been wanting to, he would have taken the opportunity to practise and gain more independence much earlier.

Mr Turquoise also explained that he and his wife were often left in the dark about his care and treatment:

> *'We didn't know anything about it [barium swallow] until we arrived back on Sunday and saw it on the notice board.'*

Later Mr Turquoise's wife talked about the case conference being a venue where she could *'find out the truth'*.

For some family members, nurses were viewed as talking in a code, which they sought to understand. A common nursing response to relatives' queries about clients was: *'he's had a comfortable night'* or *'she's been settled'*. Some family members felt that this did not really answer their question and further detail should be given.

This lack of detail contributed to misunderstandings between family members and nursing staff. For example, during one observation, one of Mrs Yellow's daughters asked how her mother had been. A support worker replied that *'she was fine, no problems'*. However, when this daughter spoke to the other daughter who had stayed over night, she had been told that her mother had been restless, in pain and had slept little. The inaccurate information provided by the support worker led to the first daughter feeling mistrustful and angry towards the nurses. Later on, the qualified nurse did not inform the daughter that her mother had been seen by the physiotherapist the previous evening. As a result, the daughter believed that her mother had not received physiotherapy input and became angrier.

Such incidences were frequent and although appearing small scale could have a significant impact on relatives' perception of the care and rehabilitation that their family member was receiving.

Carer needs overlooked

Many carers felt that nurses and other team members largely overlooked their needs for information. As Mrs Yellow's daughter explained:

> *'They don't realise that families go through it as well ... Me mum's had the stroke but we might as well have all had the stroke ... It's affecting each and every one of us in a different way.'*

Carers' needs for information varied between individuals and changed over time. But there were no apparent changes in the nurse's approach to information giving. As Mrs Red's daughter said, relating to her earlier poor experience with stroke care:

> *'I really thought that the nurses would come out to me and say, "Now look, your father could be like this for a few days but there will be an improvement" ... to prepare you.'*

Individualised approaches such as this were not observed. Indeed, from the perspective of some carers, health care staff did not give information until carers' tempers had reached boiling point:

> *'But they didn't tell us that it could have been a progression of the stroke, that it could carry on for a couple of days, they didn't explain anything like that to us, did they? ... They didn't explain anything we wanted to know, has she got pneumonia ... We had been there all day and we sat and we said we want to know what's happened and why she's back here because we didn't, you know, we didn't really know. [They said,] "Oh we'll get the doctor to you". So we sat there and sat there and nobody*

came, no nurses came. So he blew his top and then one of the senior nurses came and explained everything to us.' (Mrs Black's daughter)

Nurses commonly believed that relatives would come and find them if they needed any information. This contrasted with carers' experiences. Staff members and the information they possessed was seen as difficult to access. Mrs Black's daughter noted typically that *'there was nobody there actually, to say, if you need to know anything, come and see me'*. Or, showing both frustration and determination, Mrs Brown's husband remarked:

'I have never lost my temper as much ... One of the things that really annoys me is leaving before they tell you something ... You've literally got to grab them by the scruff of the neck and say, "Tell me NOW".'

Carers wanted more and easier opportunities to access information. They were in the midst of emotional strain and needed to speak to staff about their concerns, or ask questions.

'It would be helpful if there was a nurse who could say to people what's happening, every step along the way, a place where the nurse is on hand.' (Mrs Red's daughter)

However, it was not only members of the nursing staff who were difficult to access. Gaining appointments with medical staff posed a serious challenge: *'You've got to be there when hopefully he happens to be in the ward ... I waited five hours to see the doctor'* (Mrs Red's daughter).

Communication skills

The communication skills employed by health care professionals were also mentioned as an area for improvement. Poor communication skills, where carers felt that they were not listened to or staff members were impolite, could leave carers feeling angry and upset. For example, Mrs Pink's daughter said:

'I've never known a ward like it ... I don't like the attitude of the staff ... All you want is a bit of common courtesy ... You just don't like going up and asking them ... It's as though you're asking for the world ... everything's an effort to them. As far as I'm concerned I'm not very happy at all ... The nurse never speaks to us, they just walk past and look at us as though we are [invisible] ... But it's like you've got to chase them all the time ... You feel like you're banging your head against a brick wall. You know what I mean.'

Experiences such as this were damaging to the whole rehabilitation process for both client and carer. Indeed strained relations between staff and families could result in reduced job satisfaction and resentment towards the families involved.

Not being shown

Carers noted that they were frequently uninvolved in the client's care. They were rarely taught how to assist with aspects of treatment such as passive exercise, positioning or speech and language therapy exercises. Some relatives felt excluded, became impatient and tried to do what they thought was best. As Mrs Pink's daughter explained:

'No one's actually shown me [how to transfer my mother] ... I got fed up of waiting and ... the staff nurse came and said, "You know wait 'til the physio's shown you how to transfer, like". But ... you get that frustrated because you think, well, I'm going to sit there and I'm going to have to go up again and sort of, like, beg them to come and move her and put her in a chair. That's what you feel like you're doing.'

Mrs Pink's daughter went on to say that although she had been told that she should join in with therapy sessions, little consideration was given to ensuring that this could or would happen:

> *'They've said to us we can go in and see the therapist and go into physiotherapy with her. But ... they don't give you a time, there's no timetable, there's no set planning to it and if it was timetabled, and you said all right. It might be a bit more structured if they said you have your physio on Monday, Wednesday, Friday at 11 o'clock. Then you'd know where you stood.'*

Because of the lack of planning and communication with relatives, carers could find it hard to know when to come to the ward and how to get more involved. In addition, some carers felt that nurses and therapists neglected them, as a vital resource, by not involving them in therapy. Carers felt that while they were there, there was opportunity for them to be doing something. Others felt that it was important for them to be with their relative almost continuously, to ensure that their basic needs were met.

12.1.3 Emotional and social support

Although nurses were seen as an important source of comfort and support for both clients and carers, unmet emotional needs were widely represented in client and carer interviews.

Time to talk and counselling

In both acute hospital and rehabilitation settings, nurses were seen as too busy to sit down and talk to clients. Clients and carers expected that nurses would have had more time for this activity, but accepted that the needs of the service usually came before their needs to talk to someone. Mrs White's comment was typical:

> *'I never got any counselling about going blind ... Nurses haven't the time to talk to you now. There's not a lot of getting to know the patients as individuals.'*

Boredom and isolation

For some clients, boredom and isolation could become a source of stress that impinged on the client's sense of psychological wellbeing. Boredom could result in irritability and melancholy. This was an issue both in the hospital and in the community, where these problems persisted and even worsened.

In hospital, many clients felt that the boredom left them with no option except to sleep: *'It's sheer boredom ... you don't know what to do with yourself after dinner except sleep'* (Mr Charcoal). For other clients, long periods of boredom led to them feeling trapped and to question the purpose of their continued stay in hospital. Mr Grey explained:

> *'You've got to that stage where you are just sat there and there is nothing wrong with you, so you are just sat there all of the time. I want to go out, see how I am outside ... you only practise for 10 minutes a day ... You're sat down in a chair and that's that then ... I want to go home.'*

12.1.4 Physical support

Of particular note was the common problem of delays in the provision of physical aids to promote independence in the community. On a number of occasions, essential equipment such as wheelchairs was lacking. Two clients had been waiting several months (six and nine months) for a wheelchair to be provided. Both clients had severe hemiparesis and were borrowing their chairs (one from a neighbour and one from another nursing home patient). Both clients desired an electric wheelchair, but this option was not offered.

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Adaptations to their homes was a further area of unmet need. One carer reported his desperation for a downstairs shower to be built so that his wife could meet her hygiene needs. For a year the client's husband had been carrying her upstairs or washing her in a basin as she could no longer walk and get upstairs:

> *'It's very hard work, it's getting too hard ... it does get you down a bit ... It would be a miracle if we could have a shower.'* (Mrs Purple's husband)

Although this need had been recognised and referrals for building work been made, the length of delay was intolerable. For another carer, help around the house with laundry and cleaning and recreational support was desired. Mr Navy's son was struggling to care for his handicapped brother and his father, and did not feel he had enough help.

12.1.5 Summary

The areas of unmet need identified here have been derived from the interviews with clients and carers. It is significant that there were similarities in some of the views expressed. The main areas for concern were around therapy and rehabilitation, communication, information and involvement and support mechanisms, both physical and emotional. These all have implications for practice, but also need to be viewed in conjunction with the role of the nurse. In many cases the nurses themselves highlighted the unmet needs when they referred to their desired or potential role. Often additional or unmet needs were identified during the ongoing assessment of clients. This becomes clearer when the desired role is considered.

12.2 Desired role of the nurse

Discussion with nurses identified both deficiencies in meeting clients' needs and ways to address them, in particular, by expanding the nursing role. These, together with the view of other members of the multiprofessional team, are summarised in Table 12.1.

Desired role of the nurse from the perspectives of the:		Expectations/needs of clients and carers
Nurse	**Multiprofessional team**	
Greater responsibility for assessment: • suitability for rehabilitation • admissions affected currently by bed crises, social admissions, medically unstable clients • swallow assessment • potential for recovery • activities of daily living • *'Often the therapists don't trust the nurse's assessment. They think they lack knowledge'*	Greater responsibility for decision making: • medical care (from consultants) • assessment and planning care • be more proactive • need more specialist rehabilitation nurses	Community support for clients and carers: • physical help – *'It's a full-time job for me to do this ... I'm struggling'* • financial difficulties • enabling equipment: electric wheelchairs, quicker adaptation of housing • quality of life on discharge – being isolated *'I think you've left one prison to come to another'*
Greater involvement in goal setting		
To be able to 'do' rehabilitation/ more skills: • Bobath • moving and handling • speech and language therapy • occupational therapy • consistent skills base throughout nursing team: *'the OT is going to come in and talk to the night staff because they seem to want to come in and do nothing. They're not involved at all'* • for health care support worker	More nurse involvement in therapy: • look at care plans more • carry-over of treatment plans Better knowledge and skills for: • rehabilitation philosophy • positioning, normal movement • transfers • speech and language therapy • washing and dressing	More therapy input: *'none of the physios come to see me', 'there's not much speech therapy', 'she got more rehabilitation at home than she did here'*
Co-operative shared work: • work co-operatively with other team members • greater recognition of contributions from other members of the team • reciprocal sharing of work between team, e.g. toileting		Working consistently and as a team: • better teamwork: *'there's that many different carers come in and they don't communicate with each other'* • consistent care: *'there was one lad, he knew he wasn't supposed to pick me mam up [when she fell] on his own'*
More time with clients and carers for: • hands-on care • emotional support • activities • health promotion and prevention • to be rehabilitative, to give clients time and follow treatment plan • involving family at an earlier stage in providing physical care and with mobility • links with the community	Bigger nurse role: • health promotion, prevention and client education • emotional care • more nurse involvement family care	• Better staffing levels in hospital • Emotional support • Social activity • More information for family • Individualised care

Table 12.1: The desired role of the nurse in the rehabilitation team

Some nurses working in rehabilitation settings expressed frustration at admission procedures, desiring greater responsibility for assessing suitability for admission. It was evident that rehabilitation wards were prone to bed crises occurring in the main hospital. During these times, *'inappropriate admissions'* such as medically unstable clients or those with *'complex social needs'* tended to find themselves transferred to rehabilitation wards. This left the nurses working in these settings frustrated that they were unable to achieve the rehabilitative aims of their service. It also meant that rehabilitation beds were 'blocked', and on some occasions for long periods of time.

Many nurses desired the skills and knowledge to enable them to assess more thoroughly clients' potential for rehabilitation and progress with activities of living. The use of tools to enable more accurate monitoring of the client's condition, such as the Barthel Index, was noted as a possible way of improving the discharge planning process. It was thought that a scoring system would make it clearer as to whether clients were still benefiting from therapy or not.

Some gaps in nursing assessment were identified, such as sexuality and spirituality. Other nurses desired skills for specific areas of assessment, such as swallowing problems. The absence of sufficient therapists made this more necessary.

> *'They could wait three or four days for a speech therapist. That should be a skill we are being taught to improve quality of care.'* (Staff nurse)

Other nurses wanted to be more of a central figure in the client's entire rehabilitation pathway:

> *'I would like to see nurses assessing and introducing themselves as the named nurse, so that when the nurses went to assess ... they could eventually follow them through from assessment to home visits and maybe follow them up at home.'* (Staff nurse)

Nurses could become frustrated at the limitations of their assessment skills. When therapists could not assess or reassess a client's condition for a number of days, such as over the weekend, nurses felt that this was vital time wasted. If the clients' condition or abilities had improved or deteriorated, nurses did not always feel able to adapt care. This appeared to be more of a challenge in general settings as opposed to the more specialised rehabilitation units such as the stroke units or YDU.

> *'The patient might be able to walk but they [the physiotherapists] might say, "No, I don't want her to walk yet with you until they've reached ...", you know, whatever it is, like standing balance or ... and they maybe don't want them to transfer with a bar, or they want them to transfer to their good side or their bad side because they can over-compensate and that type of thing. Well we're not really qualified, I know what it is and I know a bit about it ... but I couldn't assess a patient on that.'* (Staff nurse)

Assessment was expressed as a source of professional power and esteem. Some nurses felt that they needed extra knowledge to be seen as being on a par with therapy staff, and others felt that other team members did not have faith in the nurses' abilities: *'Often the therapists don't trust the nurse's assessment. They think they lack knowledge'.*

However, some nurses identified gaps in the therapist's assessment skills and felt that nurses could add a more holistic approach to client assessment. It was felt that when therapy staff assessed clients' suitability for rehabilitation, they lacked medical knowledge on which to base their assessment.

> *'There's lots of problems there because they [the physios and OTs] say, "If they are walking, they are for rehab.". They don't look at what the full blood count was, they don't [look] at the U&Es [urea and electrolytes].*

They say, "Oh they can stand up, they are all right for rehab.". But they might have so many medical problems but you don't find out until you get them down here and you open the notes. They might have a urea of 40.'
(Staff nurse)

Differences in the approach and scope of assessments performed by different professionals were not the only cause of challenge. Where 'ownership' of areas of assessment was blurred, tensions within the team could occur. As the quote below demonstrates, areas of assessment were not permanently attached to specific team members. The professional who assessed particular client problems could change, depending on the structure of the team, and the personalities and skills of team members:

'Before it [the ward] was taken over as physio run, erm, it was much better. We actually went out on home visits, we assessed patients, we've had that taken off us since the physios have taken over, we don't assess any more, it is the phyios and OT ... it's diminished our role, because we used to right those problems.' (Staff nurse)

However, it was clear from observation and interview that there were many areas of assessment overlap between nurses and other team members. Some of these areas are illustrated in Figure 12.2. In many areas of client care, nurses carried out an initial global assessment where they were able to identify client problems. These problems were then referred on to other team members for more detailed and specific assessment. The nurse assessed over a wide variety of areas of client need, which made her assessment very important.

Team member involved	**Area of assessment**	*Nurse involved*
Speech and language therapist →	Communication and swallowing ←	Nurse
Physiotherapist, social worker, OT →	Personal safety ←	Nurse
Physiotherapist/OT →	Mobility, moving and handling ←	Nurse
OT, medical →	Sleep ←	Nurse
Medical, physiotherapist →	Pain relief ←	Nurse
OT/medical/psychologists →	Psychological state ←	Nurse
OT/social worker →	Accommodation/social ←	Nurse
Dietitian →	Nutrition ←	Nurse
OT →	Activities of living ←	Nurse
Podiatrist →	Foot care ←	Nurse

Figure 12.2: Areas of shared assessment

It was where the boundaries of assessment were shared between different professionals that some tensions could occur. In more specialist rehabilitation areas, nurses were more confident and had extended the boundaries of their assessment role. This could create anxieties for other team members:

'They start to move into an assessment role ... which I think they should not be doing, that's a physio's job.' (Physiotherapist)

There was concern from team members that nurses did not possess enough skills and knowledge to assess in the way that they were beginning to. This could be detrimental to clients' progress. Nurses were also seen as failing to acknowledge the specialist skills held by the other team members. On the other hand, in some areas of client care, responsibility for assessment such as swallowing had been formally negotiated over to nurses due to the lack of therapy staff. Indeed, other team members desired nurses to be more proactive in decision making and care planning.

12.2.2 Goal setting

In some wards nurses identified problems in working towards clients' rehabilitation goals. Not all members of the nursing team were perceived to be rehabilitative.

'The OT is going to come in and talk to the night staff because they seem to want to just come in and do nothing. They're not involved at all.' (Staff nurse)

Other team members, such as support workers and auxiliaries, were also seen as failing to work towards rehabilitation goals. This was attributed to lack of time, skill, knowledge and sometimes commitment. Nurses desired a consistent skills base throughout the nursing team, including support workers.

Many nurses felt that involving clients and families in goal setting was an important aspect of rehabilitation. However, within current rehabilitation practice, this was seen as an ideal, rather than a reality.

'Well, we're hoping to sort of make it more goal-setting orientated so the patient sets their own goals ... So a patient will make their own goals. And then we will sit with them and say, "What goal do you want to reach?" And once they've given you that goal "Well, how can we help you reach that goal?" ...' (Staff nurse)

This was seen as an important aspect of rehabilitation practice to develop.

12.2.3 Involving the client and family

Linked to the desire to involve clients and families in goal setting was the broader need expressed by some nurses to involve clients more in all aspects of rehabilitation. The provision of information was recognised as being neglected. As one staff nurse commented in relation to teaching carers about transfers, mobility and washing and dressing: *'No one tells them [how to do it] – well the nurses don't always'.*

From observations and interviews, it was evident that informal carers were not usually involved in client care until discharge was imminent. This could mean that for weeks and months, family members were not purposefully involved in the client's care. Some nurses perhaps lacked insight, or the skills to meet carers' needs, leading to them being overlooked or ignored.

'I think nurses in general need to realise that patients have carers and relatives and sometimes ... I think on other wards sometimes they're not given the support that perhaps they require, especially if it's a chronic illness or something causing a disability. I don't think nurses sometimes realise how the carers feel and the relatives ... and perhaps they haven't got the skills to sit down and talk to them and try and, you know, understand them or even perhaps you know refer them on to a counsellor or somebody ... Nurses will say hello to you but they won't come and sit on a chair and say, "How are you feeling as a carer?", you know ...' (Staff nurse)

Some nurses found that it was not always possible to meet the needs of both the client and the carer simultaneously. Often relatives were thought to hold different expectations of the nurse. This meant that while nurses might be meeting the rehabilitation needs of the client (by leaving clients and giving them time to wash or dress themselves) in the eyes of the family member, nurses could be perceived as being less than caring by (leaving clients to 'struggle'): *'They [the family] think we should do everything for them because we are nurses'* (Staff nurse).

When tensions did arise in the relationship between nurses and family members, it was sometimes because the carers were perceived as a threat: *'They [other nurses] might even see carers as a threat, you know, we're there to look after the patient not the carer'* (Staff nurse).

The need to involve families and clients themselves was also acknowledged by team members. While other team members recognised the role that they could play in involving families, they saw nurses as the ideal team members to take this forward.

12.2.4 Skills for client care

Many nurses expressed the need to possess better skills for direct client care. The hands-on skills required to provide rehabilitation were viewed as additional to those needed for the provision of 'basic' nursing care. Nurses said they needed to know more about how to assist clients with washing and dressing *'in a rehabilitative way'*. Even more highlighted the necessity of possessing good moving and handling skills. The provision of psychological care was also noted, with greater emphasis on developing the required skills for listening and counselling.

Other team members echoed this. They saw considerable scope in extending the nurse's contribution to providing rehabilitation care. For example, nurses were viewed as needing more skills, particularly in normal movement, to enable them to carry on from and reinforce the work of the therapists.

12.2.5 More time

Nurses desired *'more time'* in order to fulfil a number of different aspects of their role. Areas particularly mentioned related to the provision of hands-on care along with therapy integration, emotional support, health promotion and involving families in client care and activities.

Emotional support

Nurses frequently noted the need for more time to provide sufficient emotional support for clients and their families. Other members of the multiprofessional team wanted the nurse to take on a bigger role in meeting psychological needs. One psychologist wanted nurses to work towards creating a *'psychologically-minded'* unit with a much greater role in counselling. This role would then receive the same level of commitment as that given to providing physical care.

Creating the right environment

Other nurses were conscious of clients' lack of social interaction and boredom and the impact that this would have on their ability to engage with their rehabilitation. On a number of wards nurses were attempting to introduce activities to the ward such as knitting, reminiscence, bingo and singing. It was largely the qualified nursing staff who had initiated this activity, but the support worker who would be directly involved. However, difficulties in actually getting such activities off the ground arose when the ward was full of 'heavy' patients who could carry out little of their own self-care. The support workers' role in providing physical care dominated their activities and limited the time available to organise activities.

Therapy integration and carry-on

Many nurses desired more time to carry on from and integrate the work of therapists. The potential benefits for clients were recognised. However, the nurses noted that often their

contribution to therapy and rehabilitation was based on skills and knowledge *'picked up'* from working with other practitioners over time. As a result, nurses were not always confident that they possessed all of the relevant knowledge to carry on with and build on therapy. More formal skills development was required but educational opportunities for rehabilitation such as client handling were rare. Although in-service training could meet part of this need, it did not occur as regularly as desired.

Although nurses were seen as *'being supportive'* in ensuring continuity of care, other members of the multiprofessional team felt nurses could have a bigger role in meeting rehabilitation needs. First, the nurse could be more proactive in decision making, taking on a bigger role in the assessment and planning of the client's rehabilitation care. Second, nurses could carry out certain activities and treatments, such as for communication problems, swallowing exercises, ensuring correct sitting position, transferring and mobilising.

> *'The nurse can sit and remind them, make sure they're doing it [swallowing techniques] ... we can't be there.'* (Speech and language therapist)

Or, in the specialist rehabilitation unit, the nurse could supervise while the client practised preparing food or drinks in the kitchen area.

Although members of the multiprofessional team wanted nurses to be more involved with therapy activities: *'Without them doing it the right way [transfers and positioning], I'm not going to get anywhere'* (Physiotherapist), there was widespread acknowledgement of the lack of consistency in the nurse's approach. Observation showed that support workers did not always integrate and carry on the activities of therapists. There were many perceived reasons, such as time and skills, and not all of the responsibility fell to nurses. Indeed, therapy staff bemoaned staff shortages and the effect this had on treatment time for clients, and for skill sharing among the therapy and nursing teams.

Health promotion

Only a very few nurses explicitly mentioned a need to increase the time spent on health promotion. This was likewise the case for other members of the multiprofessional team.

12.2.6 Greater recognition – the co-ordinator role

The informal nature of the nurse's co-ordinator role had its benefits, but also possible drawbacks. It could cause frustrations, as it was seen to detract from direct patient care: *'It's not hands-on care, it's communicating, organising, and 'phoning people!'*; *'We just rush around like mad doing lots of paperwork.'*

The volume of work involved in the co-ordinator role was also leading to changes in the roles of qualified and unqualified staff:

> *'I think auxiliaries' jobs and trained nurses' jobs have changed. I think personally that trained nurses are being taken more away from the workplace, that is the clinical area. And there's more writing involved and more communicating with the multidisciplinary team, social workers and things like that. And so I think that ... auxiliaries have got more work, participating in the patients' personal hygiene where necessary, while nurses are taken more away from hands on. I think that is what is happening.'* (Staff nurse)

This situation could cause frustration:

> *'It does create a problem because I think you feel guilty, because you feel as though you should be [doing it], but you can only do what you can.'*
> (Staff nurse)

While nurses recognised the importance of liaison between team members, many wanted a greater proportion of their time to be spent on direct patient care, or at least recognition given for the time they had to spend on co-ordination. Indeed, in its informal nature, the co-ordinator role was perhaps partially invisible to both nurses and others. It may be this invisibility which could explain the lack of value nurses themselves attached to the co-ordinating role. This perhaps explains a comment from one staff nurse, newly appointed to a rehabilitation unit:

> *'The nursing staff have let their role go so much [to the OT] ... the OT had pushed the nurses to the side ... the nurses had let her ... I want to bring the nurse's role back where it should be ... at the forefront, more of a co-ordinating role, rather than just a care-giver.'*

The boundaries of the co-ordinating role were not fixed. These could be affected by the personalities of team members and the type of teamwork. As such, the extent to which the nurse acted as the team co-ordinator varied. Indeed, in one rehabilitation ward, the OT stated that:

> *'The OT here is a link between everybody at the moment. I'm the link between the nurses, the social workers, the physios, we link it all together.'* (OT)

Or again, the nurses sometimes felt that other team members were encroaching upon their co-ordinating role: *'We get overruled now with the physios and OTs 'phoning people at home ... Social workers, yes, fair enough'* (Staff nurse).

It was in situations like this where duplication of work was evident:

> *'Because sometimes they do need district nurses services and you try to contact the district nurse and liaise and the nursing staff have already done it so it's like duplicating work ... So I've just learnt to go to the nursing staff now.'* (OT)

Irritation could occur when one member of staff rang another, only to find that another team member had already done this. Lack of clarity as to who held responsibility for co-ordinating care could also lead to oversights, disorganisation and duplication of work. *'It's very much a team approach, but with no one really having responsibility for patients and co-ordinating care'.* (Staff nurse).

Such instances did not go unnoticed by carers and clients:

> *'There is a lack of communication there, they didn't know about the OT coming the next day ... They didn't know that the OT had booked this home visit ... But they look at you as though you are daft ... I thought, "Well, this is supposed to be a ward where you are all supposed to work together ..." but apparently it doesn't work like that, plus then the phyios didn't know that she was going to the day centre on Thursday so she didn't have any physio. So they were up in arms about that.'* (Mrs Pink's daughter)

In this case, it affected the carer's faith in the abilities of the health care team to meet her mother's needs.

The lack of clarity surrounding the co-ordinating role could also impact on teamwork. The desire was for closer teamworking with better communication and reciprocal sharing of skills. Additionally an essential pre-requisite was the correct complement of team members on the team. Without this, crucial gaps in the available knowledge and skills base existed.

Where there was no clear leader, co-ordination could flounder. In many fieldwork settings, the medical consultant felt duty bound to act as team leader. This usually involved the consultant 'chasing' other staff at case conferences or ward rounds, setting dates for review of client status and generally trying to speed up the care process. Other team members tended to accept this ambiguous state of affairs and the position of consultant as 'director'.

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12.3 Summary

Nurses expressed a number of aspects of their role which they desired to develop and expand further. Other members of the multiprofessional team echoed many of the areas raised by nurses. These included a desire for more responsibility in assessment, a greater focus on goal setting, including working towards clients' rehabilitative goals, and involving clients and carers in the process. Many staff identified a need for specific rehabilitation skills to undertake a therapy integration and carry-on role, in areas such as moving and handling, functional activities and swallowing assessments. Lack of time was also a significant issue, affecting what could be achieved for the clients, particularly in meeting emotional and psychological needs. Overall, nurses wanted their contribution to be recognised, particularly in the context of the work of other members of the multiprofessional team. Their other organisational and co-ordinating roles resulted in less time being available to spend with clients.

Key points

- Discussions in the four national expert workshops affirmed that the findings of the three case studies were consistent with the participants' own experience, knowledge and practice within the rehabilitation area.
- The health and social care professionals identified six general issues: the problematic valuing of rehabilitation and the nurse's contribution therein; the lack of recognition of the rehabilitative contribution within non-designated rehabilitation settings; the paucity of rehabilitation within the community; role hierarchy and role protectionism; the potentially wider role of generic support workers; and the need to involve clients and carers.
- Users and carers reinforced the case study findings, drawing attention to factors such as their need for information, encouragement, reassurance, continuity of care and involvement in care, and the nurse's valued role in providing emotional support, being a source of information and educating clients and carers.

This chapter presents key findings from the four national expert workshops held in part to explore the issues of the typicality and generalisability of the findings.

13.1 Issues identified by health and social care professionals

In the three health and social care professional workshops, six general issues arose:

- valuing rehabilitation and the nurse's contribution therein
- rehabilitation in non-rehabilitation-defined settings
- paucity of rehabilitation within the community
- teamworking and nurse's role in the team
- the role of generic support workers
- involvement of clients and carers.

Each is considered in turn.

13.1.1 Valuing rehabilitation and the nurse's contribution

Nurse participants in the workshops reiterated informants' comments that nursing skills and knowledge for and in rehabilitation were undervalued and under-recognised by other practitioners. Moreover, this included an undervaluation by nurses who worked in other parts of the main hospital.

Some nurses felt that clients and their carers did not fully understand the nursing contribution to rehabilitation. The expectation that nurses *'do for'* the client could create tensions in the nurse-client/carer relationship. It could also create problems between nurses and other team members when clients and carers equated physiotherapy with rehabilitation. Clients were not recognising the value of, or differentiating what was, rehabilitation nursing. This was particularly pertinent when clients' and carers' expectations of receiving 'intensive physiotherapy' were not realised on rehabilitation wards.

The lack of managerial recognition, low image and profile of rehabilitation was strongly raised by all members of the multiprofessional team. On the one hand, it was argued that managers did not see rehabilitation areas as being as labour intensive as acute surgical wards. It

seemed that their perception was that as there were more therapists in a rehabilitation setting, fewer nurses would be needed. On the other hand, there was a wider image problem, exacerbated by media coverage of acute, fast-paced areas of health care, for example, in television programmes such as *Casualty*. The negative connotations attached to caring for older people were also attached to rehabilitation. This low valuation resulted in patchy and inadequate service provision in some areas. Looking ahead, participants pointed to the benefit of consultant nurse (rehabilitation) posts in helping to raise the profile and to provide clearer career pathways for the nurse working in rehabilitation.

Finally, and most significantly, a participant at the nurses' workshop, echoing the views of others, commented: *'Rehabilitation is not acute nursing done slowly – nursing itself must be seen as therapy'.*

13.1.2 Rehabilitation in non-rehabilitation-defined settings

Participants agreed that many nurses failed to recognise the rehabilitative contribution that they could make, especially in acute and non-rehabilitation-defined settings. The educationalists pointed to the negative notion of a *'hierarchy of rehabilitation'*. In this light, specialist areas such as designated stroke units may serve to undermine the rehabilitative contribution that was and/or could be made by practitioners in other settings.

Others questioned the rehabilitation contribution of nurses working in acute settings. These nurses were seen as *'paying lip service'* to the carry-on role, and seen as more conscious of, or driven by, the need for rapid throughput. Clients admitted from acute areas were felt to have missed many opportunities for rehabilitation as a result of *'disabling'* nursing care, which promoted dependency: *'They [clients] forget how to do it themselves'* (Participant, nurses' workshop).

It was also noted that pressure from acute hospital areas could affect admissions to more specialist rehabilitative settings. Clients admitted could be acutely ill or have complex social needs, and not be ready for intensive rehabilitation.

On the other hand, it was acknowledged that it is only possible for nurses to be more involved in therapy and use new skills if their actions were based on appropriate knowledge. Nurses could then exercise their professional judgement and responsibility to carry on therapy. The need for rehabilitation link nurses for non-rehabilitation wards and in the community was suggested.

13.1.3 Paucity of rehabilitation within the community

The perceived lack of rehabilitation services operating in community settings and the role of the district and community nurses in rehabilitation was criticised. At the same time, it was recognised that many clients for whom district nurses cared did not fit into a specific category such as *'for rehabilitation'*. Their needs would be wide ranging. As a result, district nurses tended not to use the term 'rehabilitation' to describe their work.

In some cases, district nurses could feel excluded by new community rehabilitation teams or specialist nurses. Some community rehabilitation teams did not recognise a role for the nurse. On one hand, some district nurses were seen as lacking sufficient skills and knowledge to fulfil the true potential of their role in rehabilitation. On the other hand, hospital staff sometimes failed to recognise the potential role of the district/community nurse in rehabilitation.

The exact rehabilitation contribution of community nurses, whether district nurses and/or health visitors, was cloudy. Suggested elements were: *'moving the care along'*, *'providing continuity ... support'* or *'maintenance'* (Participants, multiprofessional team workshop). A potential central role could be as key worker or co-ordinator. The community nurse would also provide a vital link between the client and other team members and have a major role to play in information giving, health promotion and client education. In this context, participants noted the increasing profile of social care.

13.1.4 Teamworking and the nurse's role in the team

Some participants raised the notion of a *'hierarchy of professions'*, with some members of the rehabilitation team routinely holding greater sway over others. Nurse participants particularly felt that the focus of rehabilitation was sometimes overly related to *'therapy treatments'*, as opposed to a wider concept of rehabilitation. There was a need to value the nursing role in the prevention of complications, clinical activities, preparing clients for readiness for therapy and the provision of emotional care.

Problems with role protectionism, professional hierarchies and role boundaries were also raised. Difficulties could arise when rotational therapy staff joined rehabilitation teams but held differing expectations of the nursing contribution. It was agreed that good teamwork relied largely on the personalities of team members and personal relations rather than structures and communication systems.

Where professional roles blurred, tensions could occur if traditional areas of work changed or were perceived as being threatened by other practitioners. Skill sharing may lead to fears of professional de-skilling. At the same time, there was a desire for more shared working, for example, through the use of generic client assessment forms. Any team member could then carry out the initial client assessment, rather than the traditional reliance on the nurse.

A number of comments were made about the nurse's role in particular:

- the hospital nurse's 24-hour, seven-day presence

  It was pointed out that this only relates to nurses as a generality. In fact, there is episodic client contact with a particular nurse. She is also often interrupted when in direct client contact. This contrasts with the therapist who has focused time with one client, and is never or rarely interrupted. As a result, it may be that the therapist has more direct client time than any one nurse. The nurse is unable to protect her time. Rehabilitation is not arranged 'around' the nurse. For example, if the named nurse for a particular client is not there, then a case conference or other meeting may still go ahead. In general, it was as if there was a perception that *'one nurse equates to another nurse'*. This is not the case for therapists. Furthermore, it is likely that it is the HCA who has the most contact with a client, and may build up a relationship with that client.

- the nurse as team member

  Nurses may find it problematic to be fully involved as team members. They were often too busy to go to multiprofessional team meetings/hand-overs and in-service training. As one nurse remarked: *'Everybody downs tools at lunchtime, except the nurses'* (Participant, nurses' workshop).

- the nurse and the carry-on role

  It was questioned whether nurses really wanted to carry on specific therapy treatment. This may place the nurse in an *'assistant'* role to the therapist. Rather, nurses may be more comfortable *applying rehabilitation principles* to nursing practice, that is, integrating rehabilitation principles and practices into their work.

Finally, the importance of the key worker system was highlighted. It was suggested that the client's key worker should be chosen on the basis of need rather than being a professionally-owned role. Indeed, therapy staff were seen as needing to take on new aspects of work to fulfil key worker roles and contribute to the day-to-day running of services.

13.1.5 The role of generic support workers

Practitioners stated that they saw a need for generic support workers to improve standards of care and as a potential way to ensure a consistent skills base and approach to care throughout the entire rehabilitation team. Such workers were seen as an important development

for rehabilitation teams, and not likely to be bound by professional identity constraints. Additionally, generic support workers should potentially have the freedom, like the therapist but unlike nurses, to leave the ward. They could also have an important role to play in the community. Further education and training would be required to enable generic support workers to work in a rehabilitative way.

13.1.6 Involvement of clients and carers

The need to involve clients in the provision of rehabilitation services and their development was noted. Clients and carers must be major partners, at the centre of care and needs assessment. It was acknowledged that there were problems in current practice in keeping relatives, and even clients themselves, informed about their care. In addition, greater heed needed to be paid to their cultural and spiritual needs.

Tensions over clients' expectations of the role of the nurse in rehabilitation were discussed. At one level, nurses were often expected to 'do for' and be someone to whom clients can talk. In comparison, the therapists were expected to teach and 'do rehab.'. This difference could affect the role and contribution that the nurse felt able to fulfil. At another level, overly high expectations of rehabilitation services could cause problems further down the line for clients and their families when their rehabilitative expectations could not be met.

13.2 User and carer expectations

The comments and observations of the participants in the user and carer workshop reinforced the findings presented in the three case studies. Their comments related to two areas: user and carer needs and expectations of rehabilitation, and the role of the nurse in addressing them.

13.2.1 Expectations

A total of 11 aspects was drawn out, confirming and reiterating the observations and perceptions of the informants in the case study settings. Users and carers felt there was a need for: information, encouragement, reassurance, access to services and specialists, continuity and standardised service provision, consistency of care, more therapy at home and in hospital, good communication skills among practitioners, better discharge planning, the recognition of users and carers as individuals, and carer involvement.

Need for information

Participants described a need for accurate information and advice about the condition itself, what could be done to ease symptoms, and advice on exercise or mobility or what to expect after operations.

Need for encouragement

Encouragement was seen as vital in raising clients' self-esteem so that they would feel able to cope with their illness or disabilities. Nurses were seen as being very good at providing motivation and encouragement but often lacked time for this activity. Members noted that when services had been lacking, they had felt depressed and angry. Greater support than ever was needed at this time.

Need for reassurance

Reassurance was seen as an important part of rehabilitation. Members of the group urged health care professionals to focus more on *'the psychology of rehabilitation'*. This was important to enable people to ask questions, voice their fears and cope with shock: *'Part of the rehabilitation process is to help you to cope with the shock and trauma'* (Participant, user and carer workshop).

Need for access to services and specialists

This was a major area of concern to participants, with much of the discussion focused on the lack of specialist input. This ranged from a lack of chiropody, physiotherapy and occupational therapy to a lack of input from medical consultants. Some members of the group had gone home from hospital without any specialist therapy, nursing or medical follow up. In other cases clients had waited for many weeks and months to see physiotherapists or medical staff. Others voiced frustrations at having to go via the GP to access appointments with consultants. This was seen as creating unnecessary delays in seeing the relevant specialist. However, examples of good practice were identified. Some had benefited from good teamwork between medical consultants, therapists and nurses.

Need for continuity and standardised service provision

Frustration was expressed at the variation in service provision across different hospitals and geographical areas. Participants agreed that all services needed to work closer together and communicate with each other.

Need for consistency of care

All members of the health care team needed to share their skills with others, especially with nurses and auxiliary nurses. Boundaries between the roles of different health care workers were noted:

> *'None of them have been trained to see you as a whole person and they should be ... Each professional looks at one part of you.'*
> (Participant, user and carer workshop)

Consistency was as important in the community setting. It was very unsettling to have different social carers coming at every visit as it prevented a good relationship from being formed.

Need for more therapy at home and in hospital

There was a strong feeling that more therapy provision is required for better rehabilitation. Many participants felt aggrieved at the levels of therapy they had received in the hospital. For example, two participants commented:

> *'They left me in bed for eight weeks without any physio and my leg would not straighten.'*
>
> *'The hospital just does not give a monkey's.'*

Clients felt that they needed more input from therapists and that where possible, rehabilitation should be planned before admission to hospital.

There was an even greater sense that community provision needed to be dramatically improved: *'Rehabilitation should happen outside, not [just] inside'* (Participant, user and carer workshop).

While in hospital, clients felt cushioned from the shock of their situation. However, on discharge, participants said they felt very much alone:

> *'Every bit of care, I've had to fight for over the 'phone.'*
> (Participant, user and carer workshop)
>
> *'Care in the community does not exist.'* (Participant, user and carer workshop)

Need for good communication skills among practitioners

Many health care staff members needed to improve their communication skills. *Listening* and *respecting* clients were seen as components of good rehabilitation services. At

times this was lacking with staff behaving in a rude and unfriendly manner and failing to take into consideration the views of clients.

> *'They wouldn't let me have crutches, they said I had to use a zimmer. Why? I know I haven't got the strength in my arms. I feel like I'm going to fall over the top of it. They don't listen ... They think, "I'm the professional".'* (Participant, user and carer workshop)

Need for better discharge planning

Both users and carers felt that little planning had gone into discharge from hospital.

Need to be recognised as an individual

A common theme throughout the discussion was the need for health care staff to recognise each client as an individual. Care could appear to be routinised with little consideration given to client and carer individual needs. Family life needed to be acknowledged and both the client and family should be seen as vital members of the health care team.

Involving carers

Relatives and carers should be more involved in care if they wanted to. Many carers and relatives are very motivated and if they knew what they could do to help, they would encourage the client with exercises, mobility or walking to the toilet. Involving carers was also a way of filling the gap between what clients need and what nurses can provide, especially given staff shortages. Such shortages slowed the rehabilitation process as nurses lacked time to encourage, supervise and teach clients and carers about their rehabilitation and show them what they could do to help themselves. For example, nurses wheeled clients to the toilet rather than allowing them time to walk and practise their mobility. Another suggestion was to involve more volunteers to make sure that clients received the attention and assistance that they needed on poorly staffed wards.

13.2.2 Role of the nurse

The nurse was seen as very good at providing motivation and encouragement, itself essential for rehabilitation. She was also an important source of understandable information for users and carers, and a vital link between the consultant and client. But she lacked time to offer much encouragement or teach clients and their carers about what they could do to help themselves, as this comment, echoing those in the case studies, indicates:

> *'You are left to your own devices ... Occasionally you see a nurse wandering around ... You wait for the physio ... You don't know when she is coming, if she's coming ... In some hospitals, the nurses will sit down with you, put you at your ease, explain to you. They can tell you about your treatment, and [help you] if you have any worries.'*
> (Participant, user and carer workshop)

The specialist nurse received a particular mention for the emotional support and education she could provide. She was seen as being able to provide more time than consultants who were perceived to be very pressured. For one client with rheumatoid arthritis, the specialist nurse provided quality time where he could come to terms with lifestyle changes resulting from the arthritis:

> *'She got his head round it, he was very low ... she sat down and spoke to him.'* (Participant, user and carer workshop)

> *'It's hard when you've been an active person ... She made me feel special, she really made me feel special.'* (Participant, user and carer workshop)

Looking to the potential role of the nurse, she was seen as the ideal person to act as key worker to improve care in the community. The nurse would be able to ensure the client received all of the services they needed, such as appropriate follow-up, and ensure accurate information was provided. To do this, the nurse would have to possess a good knowledge of the local voluntary organisations, support groups, church groups, and social care packages available. The nurse could also act as a jargon buster.

The nurse was also seen as potentially being very important in supporting, encouraging and teaching clients and carers about rehabilitation. More time was needed to do this during their hospital- and community-based rehabilitation:

> *'You need someone to take away the fear and the uncertainty.'*
> (Participant, user and carer workshop)

> *'... to stimulate the emotional side, it gets people better quicker ... feed them with the will to want to improve.'* (Participant, user and carer workshop)

There was also an important, and yet unrealised, role for the nurse in preventing further health problems.

Finally, all concurred that nurses should involve carers to a greater extent in rehabilitation, through information giving and hands-on care. They should *'share rehab. with the carer'*. Nurses need to *'see'* beyond people with illnesses and their disabling effects, to clients in their family life, social setting and work environment. A desire for a wider and social notion of rehabilitation was being voiced.

13.3 Summary

All four workshops – for users and carers, nurses, multiprofessional team members and educationalists – affirmed that the findings of the three case studies, as presented, fitted with their own experience, knowledge and practice within the rehabilitation area. Indeed, the discussion within the user and carer workshop mirrored these findings. More broadly, participating specialist nurses working in rehabilitation felt that although the elements of the nursing role described related to their contributions, their own emphases lay in additional areas, in particular, in co-ordination and liaison, rather than on hands-on care. It was however noted that the exact role of the nurse would depend on the members and structure of the multiprofessional team.

The one area of reservation lay with the relative insight provided in the workshops into the hospital (*'a great deal'*) as opposed to the community setting (*'a lesser extent'*). It was acknowledged that this was in part related to the time for presentation of the findings within the workshops themselves. At the same time, the comments of workshop participants on the *'paucity of rehabilitation in the community'* were notable, notwithstanding the growing number of examples of good practice. These include:

- the work of hospital-at-home schemes (Shepperd and Iliffe, 1998)
- community-based rehabilitation teams (although seemingly predominantly therapy led/dominated)
- ways to enhance older people's independence through short bursts of intensive rehabilitation and/or care-managed support (Le Mesurier and Cumella, 1999).

In the next chapter, some of the issues that emerged from the discussion provide central themes linking the data together. Notable examples are valuing rehabilitation, therapy integration and therapy carry-on, and teamworking.

Key points

- Client and carer expectations of the nurse as someone who *'does for'* could affect the nursing contribution and the behaviour of the client.
- Six core nursing roles were identified: assessment, co-ordination/communication, technical and physical care, therapy integration and therapy carry-on, emotional support, and involving the family.
- In the hospital setting, nurses desired reciprocal sharing of some activities among the whole team, rather than only nurses taking on new roles. Nurses' continuous presence on the ward, compared to the therapists' relative scarcity, largely precluded this.
- Many nurses working in rehabilitation settings felt devalued and under-recognised.
- Differences in the nursing contribution to rehabilitation were notable across settings. Nurses in acute settings (and in some instances, in general rehabilitation areas) were not always aware of their contribution to rehabilitation. This contrasted with nurses working in specialist rehabilitation teams who had a clearer concept of their role in rehabilitation. District nurses identified changes in their role in rehabilitation, with it being less well recognised and used. Nurses in the continuing care setting identified the growing potential of their role in rehabilitation.
- The findings on client and carer unmet needs highlight the need for service users to be at the heart of the rehabilitation process.
- Ways to improve the nursing contribution to rehabilitative care relate to the nurse having more time, more knowledge and skills and the development of better teamworking.
- The nursing contribution and role in the rehabilitation can be characterised as an emphasis on *'the achievable'*. Some, if not all, nurses espoused a broad conception of rehabilitation. The extent to which they were able to integrate rehabilitation principles into care delivery was dependent on factors such as staffing and skill mix, others' valuing the nurse's role, and client and carer expectations.

This chapter provides a comparative analysis of the nurse's role across the three case study areas, drawing attention to points of similarity and difference from the sets of data, structured according to a number of areas:

- client and carer needs and expectations
- the actual role of the nurse
- nurses' valuing and understanding their role
- issues surrounding teamworking
- role variations by care settings.

It concludes by drawing out implications for nursing practice through an examination of the desired role of the nurse within the rehabilitation team. Implications for nurse education are addressed in Chapter 16.

14.1 Client and carer needs and expectations

The nurse's role in rehabilitation is very dependent on the needs with which clients presented. Ideally the nurse adapted her contribution to the individual client. However, the nurse's rehabilitation contribution was affected by client and carer expectations of the nurse. She was commonly perceived as someone who *'does for'* the client. For example:

'A lot of people come into nursing homes with the idea that we will do everything for them ... but that's not what we do here. They do whatever they can, we sort of provide the support to do the things that they can't do ... It's a bit of a battle and struggle.' (Nursing home matron)

The client did not always welcome the emphasis on 'independence'. For Mrs Red, all she wanted was peace and quiet and for the nurses to *'do for'*. From her perspective, nurses bullied and chivvied: *'You never get any peace in here, they're always getting you up ... up to the commode, sat up in bed'*.

In contrast to what clients wanted, staff on the rehabilitation team aimed to stimulate clients, keep them active and get them to do things for themselves. Thus there was often a mismatch between the clients' expectations and the goals of the rehabilitation process. This resulted at minimum in a tension, with the nurse sometimes feeling duty bound to care for the client, rather than to empower and enable independent living. Indeed, other literature (Hill and Johnson, 1999) has described how nurses working in rehabilitation with a 'hands-off' approach could be equated with being an 'uncaring' nurse. Jones et al. (1997), looking at the nature of relationships between clients and staff in rehabilitation, found that incongruence could occur when clients took on a passive role while staff expected them to be active and motivated.

Nurses sometimes felt that clients would be more active for the physiotherapist while relying on the nurse for physical assistance. Even in rehabilitation wards, nurses described the tendency of clients and carers to equate rehabilitation with therapists. Furthermore, nurses and others in the acute setting tended to describe rehabilitation in terms of *'lots of physio and OT'*. They rarely commented on a nursing input.

Client and carer needs could be divergent. It was sometimes difficult to know on whose needs to focus. For example, Mrs Red's main goal was to return to her own home. However, her daughter could not face this option (even with the reassurance of social support) previously having 'cared for' her father for three years after his stroke. Despite Mrs Red's ability to make informed judgements and decisions and her protests, it was agreed that she should go into a residential home. Of this outcome, she said: *'I was disappointed of course ... But they wouldn't release me because I needed so much care and attention'*.

Mrs Fern provides another example. The nursing staff believed that she was too frail to participate in rehabilitation and should be *'cared for'* as opposed to being continuously encouraged to care for herself. From her daughter's point of view, it was essential that Mrs Fern achieved the same level of mobility before her hip operation (although this had been very limited previously). In her eyes, the nurses were failing in their duty *'to rehabilitate'* her mother. Tensions arose and the nurses tried to compromise.

14.2 Actual role of the nurse

Six core nursing roles in rehabilitation were identified in the analysis of the three case study areas:

- assessment
- co-ordination and communication
- technical and physical care
- therapy integration and therapy carry-on
- emotional support
- involving the family.

While some nurses may undertake aspects of all of these roles at any one time, others in different situations may only be involved in one or two areas. In addition, each contribution

is multifaceted – their separation does not capture the crucial interplay and combination evident in nursing practice. Each will be considered in turn, providing an overview of the findings across case studies and rehabilitation settings.

It is important to note that each role arose across fieldwork methods (observation, interviews, record review and expert workshop discussions), settings and the multiple perspectives of clients, carers, nurses and other team members. This consistency supports the validity of the findings.

14.2.1 Assessment

Across condition case studies and care settings, in the hospital and community, the role of the nurse in assessment was crucial (Figure 14.1). Typically, nurses performed an initial assessment, from which the nursing care plan was devised and the first referrals to other members of the multiprofessional rehabilitation team were made. Nurses assessed over a wide range of areas including:

- ability to self-care
- elimination
- family/social support
- medication
- medical status
- mobility
- mood
- nutrition
- pain
- pressure area care
- social circumstances
- wounds.

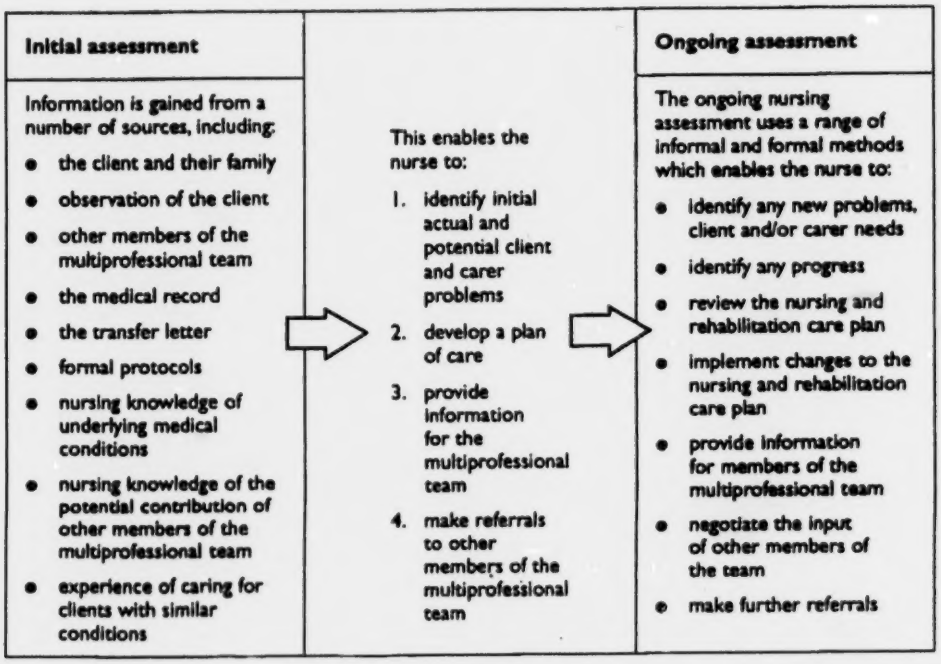
Initial assessment
Information is gained from a number of sources, including:
• the client and their family
• observation of the client
• other members of the multiprofessional team
• the medical record
• the transfer letter
• formal protocols
• nursing knowledge of underlying medical conditions
• nursing knowledge of the potential contribution of other members of the multiprofessional team
• experience of caring for clients with similar conditions
This enables the nurse to:
1. identify initial actual and potential client and carer problems
2. develop a plan of care
3. provide information for the multiprofessional team
4. make referrals to other members of the multiprofessional team
Ongoing assessment
The ongoing nursing assessment uses a range of informal and formal methods which enables the nurse to:
• identify any new problems, client and/or carer needs
• identify any progress
• review the nursing and rehabilitation care plan
• implement changes to the nursing and rehabilitation care plan
• provide information for members of the multiprofessional team
• negotiate the input of other members of the team
• make further referrals

Figure 14.1: Assessment

Nurses considered other areas according to the client's diagnosis and morbid condition. In fractured neck of femur care, observation of the affected limb and post-operative assessments were notable. For rheumatoid arthritis, the nurse's assessment focused on client knowledge levels, understanding of the disease, family dynamics and coping, as well as the ability to self-care. In stroke care, assessment of swallowing ability, communication, sleep patterns and family coping were common. These occurred together with assessments of dependency and functional ability.

In the community setting, nurses saw their assessment as being unique in combining an assessment of both health and social aspects with the prime focus on the person living in their own home.

Nurses based their assessments on a combination of formal and informal methods and protocols. Through their ongoing assessment, they provided up-to-date information for other team members. They were thus able to prevent potential problems, itself part of risk assessment, although the nurses did not described it as such. Typical areas noted were deterioration in pressure areas, risk of falls, risk of constipation or urinary infections, wound infections, aspiration pneumonia or chest infections, unwanted drug interactions, complications of surgery and potential risks on discharge from hospital.

14.2.2 Co-ordination/communication

The role of co-ordinator/communicator was another major part of the nurse's contribution to rehabilitation. The nurse was responsible for a range of activities. These included gathering, synthesising and disseminating information, liaison, negotiation and discharge planning (Figure 14.2).

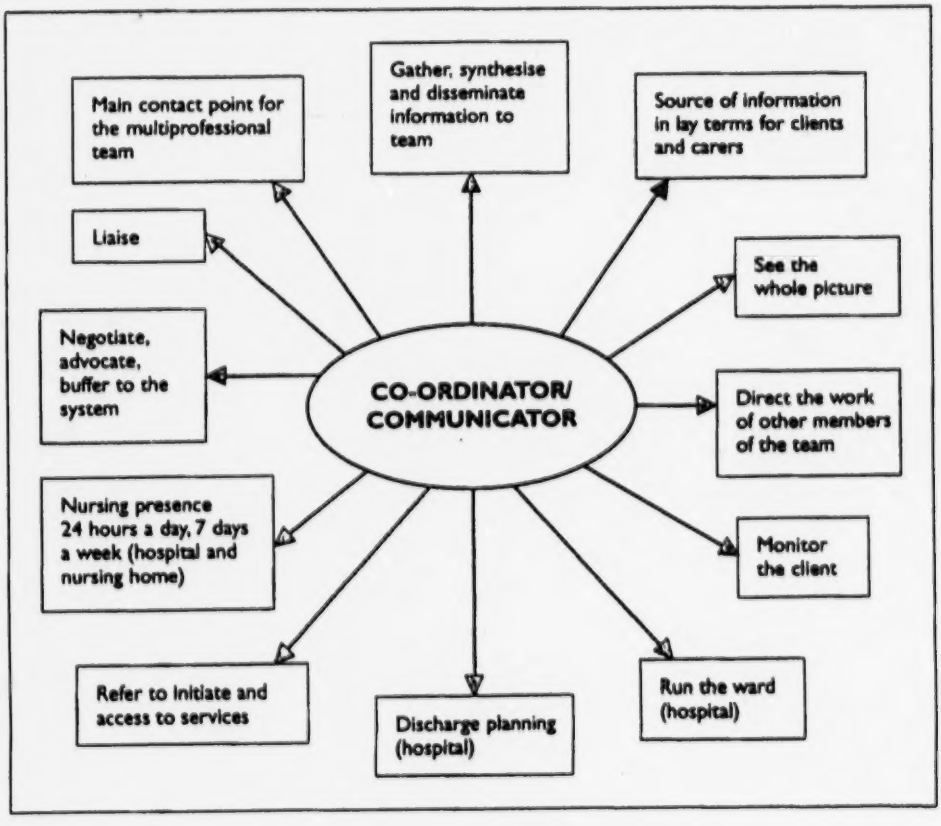
Main contact point for the multiprofessional team
Gather, synthesise and disseminate information to team
Source of information in lay terms for clients and carers
Liaise
See the whole picture
Negotiate, advocate, buffer to the system
CO-ORDINATOR/ COMMUNICATOR
Direct the work of other members of the team
Nursing presence 24 hours a day, 7 days a week (hospital and nursing home)
Monitor the client
Refer to initiate and access to services
Discharge planning (hospital)
Run the ward (hospital)

Figure 14.2: Co-ordination/communication

In the hospital setting in particular, nurses provided vital information feedback to therapy staff. The information related to the clients' progress with areas such as mobility, transferring and positioning or other activities of living (such as washing and dressing), as well as how clients were responding to treatments (such as heat or cold packs). This information enabled therapy staff members to adapt their care plans to suit the individual. Indeed, rather than being the 'non-therapeutic managers', peripheral to rehabilitation (O'Connor, 1993), this responsibility could place nurses at the hub of the client's rehabilitation and provide opportunities for further therapeutic interventions.

Another notable aspect of the co-ordinating role was the nurse's involvement in negotiation and advocacy. These contributions enabled nurses to access services and the input of different practitioners on behalf of clients. It was a role that relied on good relations with other team members, an awareness of the clients' needs and the motivation to advocate for clients and carers. For example, in the community, a district nurse was observed referring one client to a voluntary organisation, a mental health team, a housing association and social care manager. Indeed, the nurse provided a vital point of access to other services for the client or carer. Another district nurse elaborated that clients and carers were free to ring them for advice and signposting, even if this did not relate to nursing:

> *'It doesn't matter if it's not appertaining to nursing, we know a man who can ... we know the 'phone numbers, we know where to start.'*

In the hospital setting, nurses also fulfilled a 'buffering' role. This relied on good interpersonal skills. Nurses were key in managing clients' and carers' often magnified expectations of 'intensive rehabilitation'. These overly high expectations could sometimes cause tension between the family and the rehabilitation team, particularly on less well resourced general rehabilitation wards. Nurses frequently bore the brunt of complaints or criticisms, which were not necessarily related to nursing care, as a result of their continuous presence at the forefront of care provision. Examples include situations when clients did not receive therapy sessions or other team members had not communicated with each other. The nurse had to use diplomacy skills to diffuse such situations in order to retain good relations with the family. This appeared to be a tiring, unfulfilling and under-recognised role.

The nurse's responsibility for delegation, like the buffering role, also received relatively little recognition. Nurses attempted to control the flow of work, by delegating certain aspects of client care to support workers, requesting specific input from other members of the multiprofessional team and ensuring that clients were seen by the relevant team member. At the same time, nurses did not always recognise the specialist knowledge that, as qualified nurses, they possessed. Possibly as a result of this, when delegating to support workers, nurses did not always provide adequate instruction and supervision to ensure that support workers followed the rehabilitative plan of care and/or worked consistently to client (rehabilitative) goals.

In the hospital setting, a further aspect of the co-ordinating role was 'running the ward'. This consisted of a vast range of possibilities, including troubleshooting, answering telephone calls, chasing up investigations, ensuring other team members were able to carry out their work, ensuring adequate staff cover, ringing nursing agencies, booking ambulances, ringing wards or simple tasks like getting light bulbs changed. Much of this type of work was described negatively by nurses. While important, it took a disproportionate amount of their time.

Time spent on ward management competed with other responsibilities, such as hands-on care, emotional care and relating to the client's family. Nurses often felt that they were only achieving 'the basics', rather than being able to provide individualised and rehabilitative client care. This links with the findings of the small-scale study of Waters and Easton (1999) where the feasibility of providing truly individualised care was questioned. Similarly, Hill and Johnson (1999) noted that some areas of the nursing role, such as the medicine round, restricted individualised provision. However, while nurses felt that too much time was spent

co-ordinating and managing the ward, it was evident that this contribution was an expectation both from within the profession and also from other team members. Although community and specialist nurses also took on co-ordinating roles, this aspect of work did not appear to be viewed negatively.

Looking more broadly, the co-ordinating role provides insight into the incongruence between some aspects of the nurse's role. On one hand, nurses bemoaned the lack of time to spend on direct client care (which they very much valued) and blamed their responsibility for co-ordination for this. On the other hand, when describing their contribution to rehabilitation, their role in co-ordination was often the first and main contribution nurses discussed and was a source of self esteem. In many ways, it seemed that the roles of *'care giver'* and *'manager of care'* were pulling the nurse in different directions as there did not seem to be enough time to do both well.

Indeed, many nurses did not want to, or felt they should not, shed their traditional focus on *'hands-on care'* in order to concentrate more on co-ordination. Not only was there pressure from the nurse's own beliefs that the nurse *'gives care'* (and is qualified to do so), there was also pressure from clients and carers who expected the nurse to engage in practical hands-on care. It was the support workers who had to fill the gap left by the qualified nurse. But questions remain as to whether support workers are skilled and knowledgeable enough to take on responsibility for physical care. Indeed, it might be argued that the qualified nurse brings a range of 'value added' attributes to the provision of physical care, for example, ongoing assessment, evaluation of interventions, emotional support, integration of therapy and use of clinical knowledge.

In this light, one can understand why the reduced role in hands-on care and growing responsibility for 'managing care' could become a source of stress and guilt for the qualified nurse. This could manifest itself in resistance to their role as 'manager of care' and also in ineffective delegation of client care to support workers. The ultimate loser was the client, and in this context wider opportunities for rehabilitation.

14.2.3 Technical and physical care

Being the provider of technical care and of physical care were both perceived as 'routine' roles by nurses and other team members. Use of the term 'routine' is not to denigrate the activities, skills and knowledge involved. It is rather to recognise that these were the 'expectations', 'the given' that nurses would provide them. Indeed, these two roles provide examples of unique nursing contributions to rehabilitation. Both roles included a complex array of activities, which required specialised skills and knowledge (Figure 14.3).

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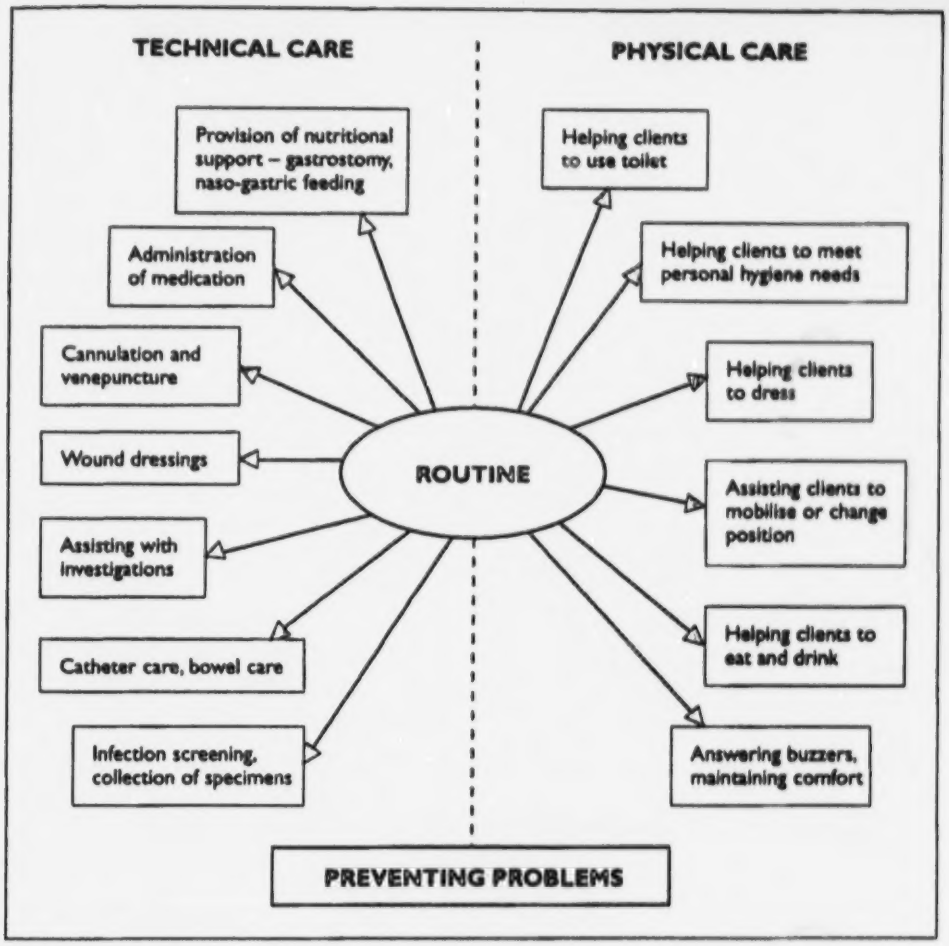
TECHNICAL CARE
PHYSICAL CARE
Provision of nutritional support – gastrostomy, naso-gastric feeding
Helping clients to use toilet
Administration of medication
Helping clients to meet personal hygiene needs
Cannulation and venepuncture
Helping clients to dress
Wound dressings
ROUTINE
Assisting clients to mobilise or change position
Assisting with investigations
Helping clients to eat and drink
Catheter care, bowel care
Infection screening, collection of specimens
Answering buzzers, maintaining comfort
PREVENTING PROBLEMS

Figure 14.3: Technical and physical care

The provision of technical care would be considered a minimal nursing contribution in rehabilitation settings where a basic criterion for admission was often medical stability. However, as the observational fieldwork showed, general rehabilitation areas in particular were prone to bed crises in the main hospital. As such, post-operative, acutely or even terminally ill clients were sometimes admitted to rehabilitation wards. At these times the nurse's contribution to technical care was much expanded, to the frustration of the nurses involved.

In the community setting, the nurse's contribution to the provision of technical and clinical care had grown, to the exclusion of many aspects of physical care. This reflects the greater number of acutely ill clients in the community, rationalisation of the district nursing role and the increased use of social care. This was not an entirely welcome development, as lack of involvement in providing physical care precluded the integration of physical and emotional forms of 'therapy' into activities of living.

Ensuring the client's physical care needs were met comprised a large part of the nurse's so-called 'routine' work and is consistent with Kirkevold's (1997) description of the 'conserving' function of the nurse. The provision of physical care involved the qualified nurse undertaking varying degrees of hands-on involvement, such as assisting with washing and dressing or elimination. More often than not, however, the nurse delegated to auxiliary/support workers who carried out the majority of physical care.

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14.2.4 Therapy integration and therapy carry-on

Closely connected to the provision of physical care was the nurse's role in therapy integration and therapy carry-on (Figure 14.4). This has resonance with Kirkevold's (1997) 'integrative' role.

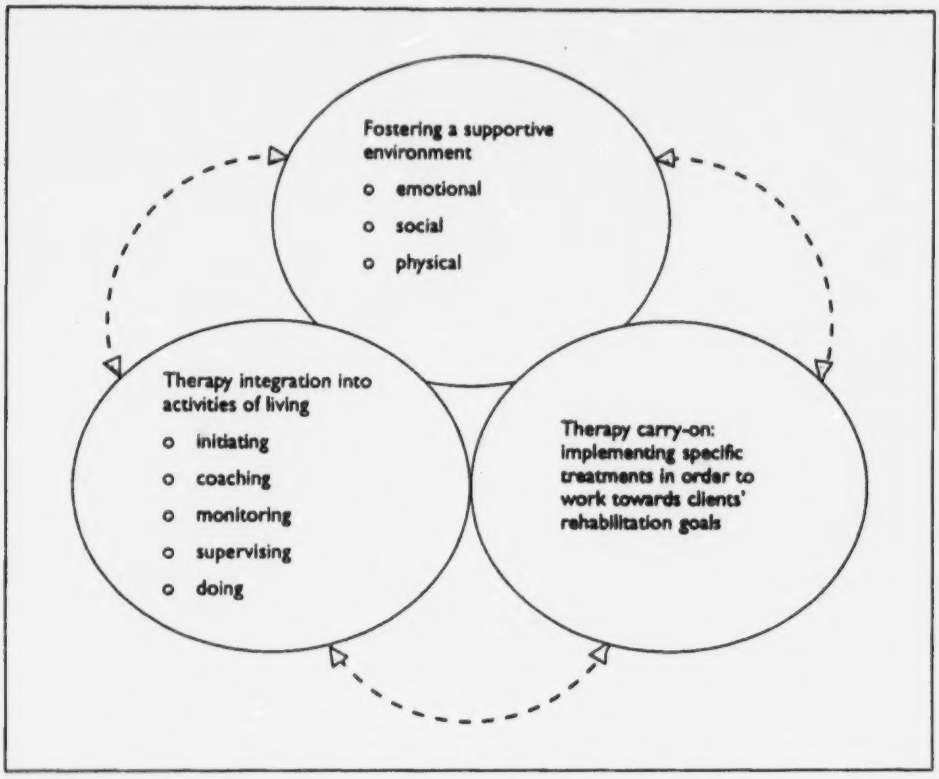

Figure 14.4: Integration of therapy and therapy carry-on

Therapy integration involved two interconnecting aspects. The first related to the nurse's attempts to create an environment which itself was therapeutic and facilitated rehabilitation, often through addressing possible emotional, social or physical barriers which might inhibit rehabilitation. The second involved the nurse building on the work of the therapists.

Creating a supportive environment itself had three parts: emotional, social and physical. Each could go some way to create an environment conducive to rehabilitation, which gave clients *'a push along the way'*.

Nurses provided emotional support, encouragement and motivation by building up a supportive relationship with clients. Where possible, nurses tried to give clients choice, include them in decision making, and give them time, space and encouragement to try new things for themselves. This encouraging, supporting and motivating role was a more diffuse and subtle element to the nurse's contribution, but nonetheless vitally important. It could be linked to Henderson's (1980) notion of the nurse's role in 'humanising' the care process.

Nurses recognised the value of social activities as a way of facilitating and enabling rehabilitation to take place, by creating a more sociable and stimulating environment. Their aim was to prevent clients from becoming isolated, lonely, bored or depressed as a result of their condition and their lack of opportunity for interaction with others. For example, the district nurse was observed encouraging one of the stroke clients to attend the coffee mornings in her sheltered accommodation. She wanted the client to get used to being with people again, to increase her confidence and to have the opportunity to practise speaking despite her expressive

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dysphasia. Or, in the hospital setting, nurses tried to organise communal meal times, as opposed to sitting by the bed, or to play bingo. However, nurses found it difficult to initiate social activities on a formal basis due in part to resource constraints and the unpredictability of their work. At the same time, the use of humour, banter and everyday chat was commonplace.

Nurses also gave consideration to the physical environment. In the hospital setting, nurses took note of whether clients were happy in single rooms, or bays, and the impact that other clients were having on their mood. They could move the client's bed, or ensure that cards from family and friends or flowers could be seen, or play music at certain times. In the community, the district nurse might initiate changes to the client's furniture, to make it safer or to help the client move around their house.

The nurses could then begin to integrate the work of the therapist and the clients' new abilities into their activities of living. Examples include:

- taking the time to use the correct transferring or positioning techniques when getting in or out of bed
- coaching and supervising the client as he goes to the table
- using the same techniques as the OT when washing and dressing in the morning or at night or adjusting clothing during the day.

To varying extents, qualified nurses and support workers tried to temper the tradition of *'doing for'* with a *'standing back'* approach in order to fulfil this role. Much of this integrating contribution went unnoticed, as it was seen as routine and everyday. This was unlike the time-limited, specialised and discrete episodes of treatment provided by the therapist which were highly visible.

Typically, the nurse's contribution to integration was mostly recognised when it was absent. Indeed, in all settings, the needs of the service to get all clients ready for the day tended to inhibit staff from standing back and integrating therapy. Immediate demands on the nurse's time tended to take priority over pre-planned client care. In the hospital setting specifically, from the perspective of other team members, nurses were sometimes perceived as being overly preoccupied with 'getting the work done' (Melia, 1987), to the detriment of working towards rehabilitation goals. Nurses were at times seen as working towards different priorities:

> *'Therapists and nurses have a different agenda in the morning. The nurses are wanting to get people up and dressed quickly and have their breakfast ... We tend to take much longer, because what we're wanting to achieve out of the washing and dressing is to promote the patient's independence within that session ...'* (OT)

In the community setting, it is clear that social carers work to similarly pressured 'time slots' for each client they visit. As a consequence, despite the ideal of following rehabilitation programmes at home, this may not be the reality. From the perspective of other team members the impact on the client was delayed recovery and rehabilitation times. Indeed, the pervasive view was that without nurses and support workers following the same approach as therapy staff, clients would not benefit from rehabilitation treatment.

Where client needs were complex or unusual, other team members provided specific treatment instructions or 'prescriptions' to be followed by nursing and support staff in these areas. Examples included the nurse carrying on passive exercises, using heat or cold packs, putting the client on a tilt table, putting on splints, supervising a client doing swallowing and speech therapy exercises, and thermal stimulation. This would be in addition to the nurse integrating more general therapy activities such as positioning, transferring and mobilising or washing and dressing. Like some aspects of nursing, these aspects of therapy were almost routine and were often initiated by nurses without direction from therapy staff.

It was notable that in the more specialised stroke units, nurses were more confident in their abilities to contribute to both therapy integration and therapy carry-on. Nurses were much clearer as to the necessity of this contribution to client care and had incorporated these areas into the totality of their role. They described themselves as *'specialist nurses'*, itself a powerful indicator of morale. This contrasted to the self-depiction of those who worked in general rehabilitation as *'nurses who worked in rehabilitation'*. They appeared to feel that their contributions were little different to those nurses working in any other setting.

In the rheumatoid arthritis case study, very little integration of therapist-related work was visible. More emphasis was given to creating an emotionally supportive environment with the provision of encouragement, reassurance and motivation, as opposed to carrying on specific exercises or therapy treatments, or integrating joint protection into activities of living. Furthermore, although nurses described some physical aspects of rehabilitation in which they desired more involvement (for example, joint protection) interviews revealed a different emphasis in their interests. They wanted greater involvement in the psychosocial aspects of rehabilitation, including counselling, coping strategies and issues of sexuality. This was perhaps indicative of a different emphasis on the role of the nurse, away from physical care giver towards a more enabling role.

In the stroke and fractured neck of femur case studies in particular, many nurses wished to expand their role in the provision and reinforcement of therapy, *'to do rehab.'*, in order to ensure better continuity of client care and more effective rehabilitation. Other team members also saw great scope in an expanded nursing role, in particular in reinforcing the physical therapy that they prescribed. Clients and carers also wanted more therapy. Long periods of inactivity and boredom resulted in frustration and many clients did not feel that as much progress as was possible was being made. Closely linked was the nurse's wish for greater opportunities to organise social and rehabilitative activities for the clients, recognising the damaging effects of boredom and inactivity on the rehabilitation process.

Even in the specialised rehabilitation units, time constraints, work priorities, and skills were crucial hindrances to achieving this desired role. Nurses frequently complained of being rushed, especially in the mornings when washing and dressing activities were ongoing. They felt unable to spend enough time with each client. This meant that they did not always work in a rehabilitative and individualised way. Rather, nurses felt forced to approach their work as a series of tasks to achieve in a set time.

14.2.5 Emotional support

Within all case studies and settings, the nurse fulfilled a key role in providing emotional support (Figure 14.5). This role was considered by many practitioners to be a special and unique nursing contribution. While time consuming and tiring, nurses valued the opportunity to build a supportive relationship with clients. Furthermore, clients and carers frequently praised the personal characteristics of individual nurses. Particular individuals appeared to stand out because of the positive impact on the client's mood and outlook that they were able to promote.

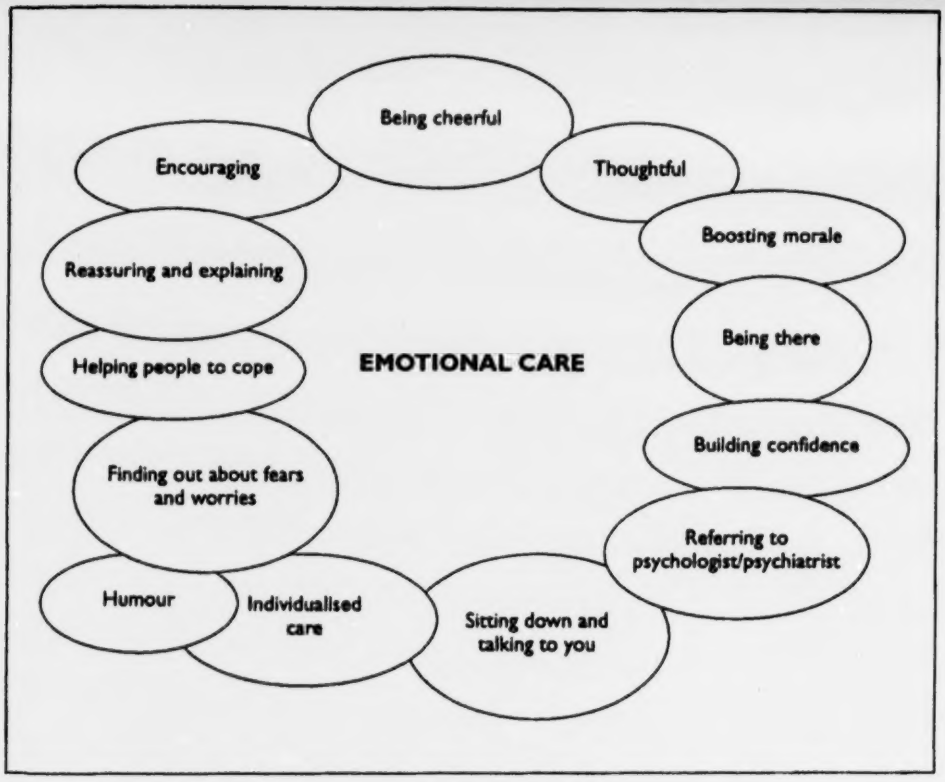

Figure 14.5: Emotional support

This contribution is closely related to Kirkevold's (1997) 'interpretive' and 'consoling' roles, whereby the nurse tries to assist the client to come to terms with, and understand the ramifications of, their condition – this itself being enabled by friendship and a trusting relationship.

Nursing contributions to emotional support were, however, rarely documented in nursing notes. More often this was an informal activity discussed among the nursing team. In the rheumatoid arthritis case study, the emphasis was on enabling clients to cope, adapt and problem solve ways around the barriers that the illness posed. Unlike the other two case studies, the term 'empowerment' was frequently mentioned. In the stroke and fractured neck of femur case studies, nurses tried to find out about clients' and carers' worries and fears, providing advice or reassurance where appropriate.

Nurses continually noted the lack of time to provide emotional care. For many, the lack of time to *'be with clients'* was a source of frustration and guilt. Indeed, there was implicit recognition that emotional support was one of the crucial ingredients of creating a supportive environment in which rehabilitation could happen (cf. Nolan et al., 1997b). There was a need for an emotional and social climate where clients would feel supported as they faced the future or began to try and develop new physical abilities.

14.2.6 Involving the family

The activities of providing information, emotional care, communicating and co-ordinating were all parts of the nurse's attempts to involve the client's family (Figure 14.6). As the most accessible practitioner and the member of staff clients were most accustomed to, nurses by default were often viewed as the first port of call, when seeking information or advice. This was the case both in the hospital and the community: *'The carers are on the 'phone as soon as they have a problem'* (District nurse).

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However, across case studies, the bulk of the evidence from clients and carers painted a picture of inadequate involvement and information provision, similar to that highlighted by Nolan et al. (1997b). In the fractured neck of femur case study, carers noted that they were not involved in discharge planning. Rather, they were informed of the date for which discharge had been set. In the rheumatoid arthritis case study, although clients expressed a desire for family members to understand their disease better, nurses did not provide educational information specifically for family members. In the stroke area, families found it difficult to find out how to assist their relative with mobility and transferring or to get involved in therapy.

The isolated examples of good practice, where families had been closely involved in decision making and provided with accurate and up-to-date information, stood out clearly. The potential of the nurse to act as an assessor of family members' needs, as described by Hymovich and Hagopian (1992), was largely unmet.

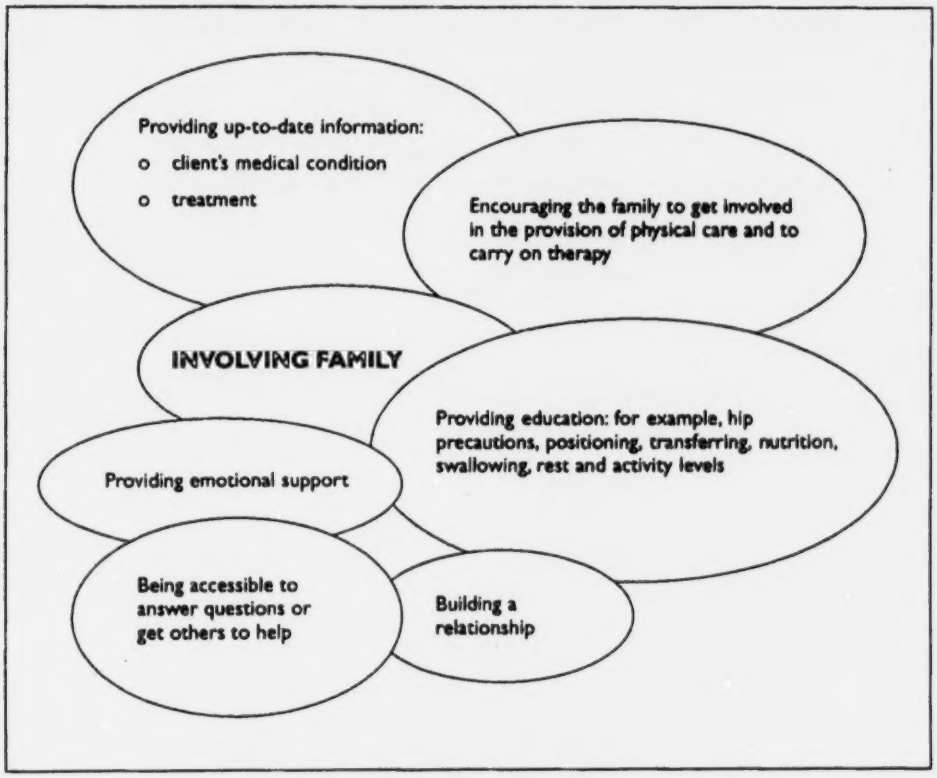
Providing up-to-date information:
o client's medical condition
o treatment
Encouraging the family to get involved in the provision of physical care and to carry on therapy
INVOLVING FAMILY
Providing education: for example, hip precautions, positioning, transferring, nutrition, swallowing, rest and activity levels
Providing emotional support
Being accessible to answer questions or get others to help
Building a relationship

Figure 14.6: Involving the family

14.3 Nurses' valuing and understanding their role

14.3.1 Valuing their role

Many nurses working in rehabilitation settings felt undervalued and under-recognised as a specialty by the nursing profession itself. There was a sense that negative connotations attached to nursing older people were also attributed to rehabilitation nursing. This was perhaps partly why some nurses working in rehabilitation appeared not to value and recognise the importance of their total role in rehabilitation and the specialist skills that they used. Many saw their role as being fragmented and disparate. This compared less favourably with the roles of therapy staff members, which were perceived as being more tightly defined and specialised.

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'As far as the nurse, what can we say, we're here to encourage you to mobilise, pick you up when you are feeling low, to give you your medicines on time, or to liaise ... We're at the hub and we're sort of pulling the strings together, but there's nothing I can clearly define and say ... this is what I do.' (Staff nurse)

'Nurses are not specialists in anything, and yet we do everything.' (District nurse)

When talking about nursing contributions in rehabilitation, some nurses saw their skills as being no more and perhaps even less than those of nurses working in health care settings whatever the specialty. Added to that, nurses downplayed the contributions that they actually recognised as being particularly important. For example, when discussing emotional care, a staff nurse remarked: *'I wouldn't say it is a special role ... anybody can sit down and just talk and listen'.*

Indeed, some team members felt that many nurses (even those working in rehabilitation settings) did not recognise the full scope of their potential contribution to rehabilitation, particularly in relation to therapy integration and therapy carry on.

14.3.2 Understanding their role

Members of the multiprofessional team felt that some nurses' understanding of their role and the concept of rehabilitation was limited, affecting the way that they approached their work. Nurses were seen as working in a task-orientated and disempowering way, approaching their work with clients as work to be done rather than opportunities to integrate therapy. However, the nurse's own perception of her role in integrating therapy was varied. Their views ranged from seeing therapy as purely the therapists' domain, to it being an optional extra in which nurses could be involved if they wanted, to seeing it as a core aspect of rehabilitation nursing.

It was notable that in several hospital settings nurses' routes into rehabilitation had been via non-rehabilitation areas such as acute care, medical care and care of the elderly. In some cases, rehabilitation wards had been created overnight out of medical and other wards. The same staff remained, little educational preparation was provided and yet the focus of the service had changed dramatically.

It is thus perhaps unsurprising that some nurses felt lacking in the relevant skills and knowledge to contribute to rehabilitation. Some nurses identified a lack of skills for meeting psychological needs or carrying out treatments such as thermal stimulation. Others felt that if they were to be expected to carry on from therapists, as accountable practitioners they should be knowledgeable of the research evidence to support these actions, rather than only knowing the 'how to' of these actions. This lack of knowledge and confidence has implications for the level of information the nurse felt able to relay to clients and carers.

14.4 Issues surrounding teamworking

Although multiprofessional teamworking has been championed as the means of providing effective rehabilitative care, a number of challenges were identified.

14.4.1 Nursing time

The lack of nursing time in relation to the provision of hands-on care, emotional care, therapy integration and therapy carry-on made it difficult for nurses to be active members of the multiprofessional team in other ways. Although multiprofessional team meetings were frequently established, nurses were often unable to attend due to poor staffing on the ward. This meant that nurses could not effectively communicate with or receive information from other team members.

Skill mix issues were also relevant. In some hospitals and community settings, there was a serious shortage of therapy staff. This was a problem over which nurses had no control. Yet the impact on the nurse's role, the workings of the team and the service were considerable. Nurses saw a need for specialists who would be able to deliver therapy in discrete episodes. Too often, therapy sessions were viewed as being too infrequent to be of value.

In the community (although not exclusively) it had become a matter of principle for some nurses that they would not carry on work for therapy staff. Community staff commented that as long as nurses continued to embrace work perceived to fall within the roles of other members of the health care team, the service would not recruit the required number of 'specialists'. They did not wish to be a *'stop-gap'* for missing essential team members.

14.4.3 Working patterns

Differences in shift patterns impacted on effective teamworking and sharing of skills. The issue of who worked when was a constant theme. The fact that in most settings, members of the therapy staff work 8a.m. to 5a.m., Monday to Friday, was a constant stumbling block. In some settings, this lack of flexibility was a cause for resentment. The absence of therapy staff at weekends also affected nurses' approach to care. There was a tendency to work along routines rather than via rehabilitation principles. From the nurse's viewpoint, the reason for this more task-orientated approach was the scarcity of pairs of hands. More broadly, however, rather than having all team members present all of the time, it might be more appropriate to consider how to share core skills across the team.

14.4.4 Information exchange

Shift patterns challenged effective communication within the team. Nurses often handed over the same information to different team members, several times over in the space of a few hours. Methods of sharing information were not always effective. On one hand, some members of the multiprofessional team felt unable to spend the necessary time writing detailed instructions in nursing care plans for areas such as washing and dressing, or moving and handling. On the other hand, nurses and unqualified members of staff were not always viewed as good at following instructions written in care plans. Verbal hand-overs were also sometimes lost in the hubbub of ward activities. In this process, information could become inaccurate with consequent impact on client care.

14.4.5 Not feeling valued

Issues of inequality within teams caused problems. Some nurses explained that they did not always feel valued within the multiprofessional team. While there was an expectation that nurses would co-ordinate clients overall care, nurses sometimes felt that the information that that they provided was ignored or overruled: *'We can't get anyone to listen to us'* (District nurse).

Professional tensions could arise when nurses felt that their skills and knowledge were not recognised or valued by other members of the multiprofessional team. This was perceived when therapy staff taught nurses about areas of care that they felt confident and competent in (such as feeding a dysphagic client). This sort of tension was more noticeable in stroke rather than general rehabilitation units. Nurses in specialist unit were 'protective' of their own specialism and confident in their skills.

Some nurses became frustrated with team members' limited perception of the nursing role. For some, their role had been marginalised or excluded by the strength of therapy roles, which were shaping and influencing the nurse's contribution to rehabilitation.

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14.4.6 Skill sharing

Nurses recognised a need to make the best use of the resources and personnel currently available. They indicated that some members of the nursing team (such as night staff) missed out on opportunities to learn new skills as they worked only infrequently with therapy team members. Other nurses felt that support workers should be facilitated in developing their skills further as key team members. Many nurses also wanted better sharing of skills within the team so that members of the therapy staff shared their expertise with others, for the benefit of client care. However, the level of joint working was minimal in all fieldwork areas.

> *'When you work on the ward ... and you're doing your nursing jobs and the physio comes on and you say, "Hello" to the physio and you have a bit of a chat ... Then the physio will walk down the ward with the patient ... That's all you ever see of them.'* (Staff nurse)

In the community setting, nurses and social carers worked infrequently with therapy staff and were thus unable to develop further skills and knowledge. This form of fragmented teamwork could result in inconsistencies in care.

Not all practitioners were open to skill sharing. On one hand, nurses sometimes felt that other team members were *'protectionist'* over their skills and knowledge. On the other hand, other team members felt that nurses sometimes held *'rigid ideas'* of other team members' roles. In settings where staff members worked closely together, there was both scope for tension, but also great potential for creativity.

14.4.7 Working the boundaries

In all of the case studies, but particularly in the stroke case study, nurses were working along new and constantly negotiated working and role boundaries. Negotiation of work contributions was an issue of current concern. Often the relationship between nurses and therapists could be viewed as a 'push-pull' scenario. Some nurses working in the hospital setting felt constantly *'put upon'* to carry on from the work of different professional groups. Many had taken on extra roles such as cannulation, venepuncture, and administration of intravenous medication. These increased work pressures. There was a sense that it was only nurses who were prepared to take on new areas of work as the boundaries of professional roles blurred.

While nurses desired reciprocity in sharing the physical workload, they also wanted to share their nursing expertise with other team members. They perceived this as a way of facilitating more holistic client care. In contrast, there was a feeling that therapy staff took a fragmented approach to client care, for example, concentrating on mobility while not looking at wider aspects such as how the client might negotiate the bathroom: *'... we have to come together for the benefit of the patient'* (Staff nurse).

Where reciprocity was not forthcoming, tensions within the team could arise:

> *'A lot of nurses get peeved because we are expected to do physio and OT work, but they won't put patients on the toilet, which is all part of physio and OT ... They'll shout out for an auxiliary or they'll shout for one of us!'* (Staff nurse)

However, it was clear that there was little incentive for other team members to carry on from nursing work due to the nurse's continuous presence on the ward compared to the scarcity value which therapy staff commanded.

While other members of the multiprofessional team desired that nurses expand their role and take on a more therapy-based approach to client care, there were clear boundaries to the nurse's role in carry on. Sometimes competition for and 'ownership' of areas of professional work and responsibility could arise:

'You do wonder sometimes, if you give the nurses too much nutrition training ... There are some nurses who take on dietitian roles.' (Dietitian)

Tensions between therapy and nursing staff could also arise when nurses asserted themselves within the team.

'The nursing staff can be quite defensive ... they will actually say to you, "This is a 24-hour rehab. unit, it's not just the therapists" ... They'll walk all over you. They know the patient best. They're in control.' (Physiotherapist)

Some therapy members of the team seemed to misunderstand the motivation behind the nurse's attempts to take on a greater role in therapy. Nursing role expansion was almost perceived as a professional development exercise encroaching into the work of other professionals, rather than as a genuine attempt to improve the quality of rehabilitative care which clients would receive.

14.5 Variations by care setting

Differences in the nurse's role and contribution were notable across settings of care:

- acute care
- rehabilitation settings
- the community
- continuing care.

14.5.1 Acute care

Apart from a few individuals, nurses working in acute areas (acute medical more than acute orthopaedic) did not always consciously recognise their actual or potential role in rehabilitation. The focus of their care was meeting the needs of acutely ill clients, although nurses undoubtedly contributed to some aspects of rehabilitation as well. Indeed, nurses could make all the difference to the clients' experience of hospital care:

'He [the charge nurse] was just so nice, you know, he really cared about his patients, I'm not saying that the others didn't, but he'd sit and talk to you, he was great.' (Mrs Garnet)

It was not unusual for clients to spend their entire rehabilitation pathway, or a considerable portion of it, on an acute ward. Because of the location of care, therapists did not always work closely with nurses or try to involve nurses in what they had done. This had implications for the sharing of skills and client-focused rehabilitation goals.

Other team members did not feel that nurses would have time to assist with their work in any case. Rehabilitation came further down the list of priorities: *'we just do the basics'*. This is similar to Newell et al.'s (1997) findings that qualified nurses spent little time assisting clients with therapy or recreational activity.

From the perspective of those nurses working in designated rehabilitation areas, nursing care in the acute setting, rather than being rehabilitative, was seen as *'disabling'*. There was a sense of a 'hierarchy' of rehabilitation with specialist rehabilitation areas at the top, and acute areas at the bottom. The location of community rehabilitation was unclear. Nurses in the acute setting appeared to resent the tight admission criteria which rehabilitation wards used, with rehabilitation wards taking only the reasonably able clients. This left acute settings to care for very disabled and dependent clients who were perceived to have less, or no, potential for rehabilitation.

'Rehab. has got very strict criteria on who they accept. They only take strokes who are sat by their beds, eating and standing on their own two feet. They don't want the ones who are ... [nurse imitates a sprawled posture and facial grimace] in their bed.' (Staff nurse)

At times, nurses felt unsupported and unsure as the best ways to facilitate a client's rehabilitation, arguing that more specialist therapy input was required. This perspective was echoed by other team members who felt over-stretched by the number of wards they had to cover.

14.5.2 Rehabilitation settings

It was not only staff in acute areas who felt neglected in terms of rehabilitation resources. Those working in designated rehabilitation settings also felt undervalued particularly by management who were seen to favour acute care. In the stroke case study, differences were apparent in the nurses' perceptions of their role in general rehabilitation settings in comparison to the more specialist stroke units. Some nurses in general rehabilitation saw themselves as *'nurses working in rehabilitation'*, as opposed to *'rehabilitation nurses'*. That is, there was little recognition of specialist skills additional to those possessed by *all* nurses.

In contrast, nurses working in specialist areas had a clearer concept of their actual and potential role in rehabilitation, viewing themselves as providing nursing care using extra-rehabilitation principles. There was a visible difference in their actual roles with greater involvement in therapy activities, although this was not consistent throughout the nursing team.

Differences in bed usage also seemed to be related to whether the unit was a general or a specialist rehabilitation unit. In the stroke case study in particular, not only was therapy cover less consistent in the general rehabilitation settings, but these areas were also less able to protect their beds from the pressure of bed crises in the main hospital. This meant that clients deemed unsuitable for rehabilitation were admitted, with implications for the nursing role and contribution to rehabilitation: *'He's a social problem, not a rehab. problem ... he shouldn't even be here'* (Staff nurse).

14.5.3 The community

Inadequacies of service provision were noticeable and highlighted by practitioners in hospital and community settings and by clients and carers. Community services were patchy, leaving clients unsupported by specialist practitioners. In the rheumatoid arthritis and stroke case studies in particular, a lack of specialist multiprofessional care (such as physiotherapy, occupational therapy, podiatry, social work and specialist nursing) left clients and carers frustrated and disappointed. Other problems related to the provision of aids such as wheelchairs and adaptations to houses. Physical help for carers was also problematic, often putting elderly carers under strain.

This was perhaps why hospital nurses in both the rheumatoid arthritis and stroke case studies wanted to expand their roles to link to the community. Rehabilitation nurses felt that they could offer further support to clients after discharge from hospital via follow-up home visits. Others felt that rather than being admitted to hospital, some clients could receive (enough) support on an outreach basis.

Focus group discussions with district nurses revealed a positive view of the district nurse's potential role in rehabilitation: *'We do it all the time ... people think it's a therapist's job, but we do have a role in rehabilitation'*. District nurses considered their current practice to be holistic. They identified major roles in the assessment of client and carer needs, referral on to other agencies and teaching, motivating and encouraging with a view to enabling clients and carers to adapt to their new circumstances.

However, they felt that their role in rehabilitation had changed dramatically, becoming less well used and less recognised. Indeed, there was a widespread perception that others (therapists and nurses) did not see the district nurse as having a role in rehabilitation, and had a limited understanding of the district nurse's role in general: *'People think you are a generic nurse, that you don't know anything about rehab.'* (District nurse).

Reflecting this, district nurses commented that referrals for rehabilitation were rare. They were contacted (via poor hospital discharge information) to remove sutures, dress wounds, assess pressure areas, treat diabetes and such like. Furthermore, not all clients with so-called social needs were referred to the district nurse. With the divide between health and social services, many referrals bypassed the district nurse. From the district nurse's perspective, this only meant that the client or carer would present at a later stage, unable to cope and with many areas of unmet need.

District nurses wanted to be involved with clients at an earlier stage so that problems could be prevented. Indeed, much of the district nurse role in rehabilitation was now perceived to be carried out by social carers (washing and dressing being noted in particular) with more specialist functions taken over by community rehabilitation teams. Many felt that the nature of the district nurse's role had changed such that it was focused on the number of client contacts and measurables achieved rather than rehabilitation: *'We could do more with them but we don't have time'* (District nurse). Indeed, observation of district nursing practice demonstrated that the roles of the different community practitioners, rather than being blurred as in some hospital settings, were clearly demarcated.

This change in roles met a mixed response. Some district nurses did not feel that it was their responsibility to be heavily involved in rehabilitation. If they did take on these new responsibilities, the impetus to getting the right therapy members of staff working in the community would decrease. Others felt that they were being de-skilled and believed that their current knowledge base was now out of date. They wanted more joint working and assessment with other team members such as physiotherapists and OTs. The knowledge gained from joint working would enable them to facilitate clients' rehabilitation.

Yet other district nurses wanted a greater involvement in rehabilitation (rather than being excluded) in order to take part in developing the social care workforce which was very much seen as a *'doing for'* service. The tendency of social carers to 'do for' meant that rehabilitation programmes initiated in the hospital setting were often not carried through. In consequence, opportunities for clients to increase their independence were lost. There was thus an important role for the district nurse to ensure that such programmes occurred. The emphasis on physical care also neglected the more social aspects of rehabilitation that many clients were concerned with. Nurses wanted closer working between health and social care.

Other nurses saw great potential in their increasing involvement in the commissioning process, health needs assessment and contribution to health improvement programmes. Some also saw scope in the community nurse acting as care manager, co-ordinating rehabilitation packages.

14.5.4 Continuing care

The continuing care environment was undergoing a period of change. Interviews with nursing/residential home matrons revealed the increasingly acute care needs of residents and greater relevance of rehabilitation, as predicted in the literature (Nazarko, 1994). Matrons described their contributions to rehabilitation in positive terms, noting many examples of specific clients whose improvement, while unexpected, had been nurtured by the staff of the nursing/residential home. Indeed, the language of care in this setting was notably different, with an emphasis on providing residents with pleasure, social activity, choice and security:

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'It's their home ... staff are more loving ... more time to spend ... It's a relaxed atmosphere ... It feels very secure ... very different from the hospital ... There's always laughter.' (Nursing home matron)

Matrons also described the therapy integration and carry-on role in positive terms. This was seen as an area for greater development. There were difficulties accessing the expertise of 'specialists', such as the speech and language therapist, causing delays in adapting client care. At the same time, nursing home nurses did not always feel they had the relevant skills and knowledge to implement the best plan of care. This was particularly important as the qualified nurse frequently supervised a group of care assistants who worked as the client's key workers.

From interviews with clients living in these settings, it was evident that homes were not immune to the pressures of high workload, short staffing and a tendency to *'do for'*. Observational data showed that some nurses and care workers lacked adequate moving and handling skills, putting themselves and clients at risk of injury. This was not unnoticed by care home staff who indicated that the risk of getting *'out of date'* (both qualified staff and care workers) in the nursing home sector was a current concern. Indeed, all matrons interviewed undertook active and self-motivated education.

14.6 Summary: implications for practice

This chapter has provided a comparative analysis of the findings arising from the three case study areas. At its centre are two main areas: the importance of meeting client and carer needs, and perceptions of the role of the nurse within the multiprofessional and multi-agency rehabilitation team.

The findings on client and carer unmet needs are consistent with those highlighted in Nolan et al.'s (1997b) literature review. Similarly, this research has revealed deficits relating to clients' and carers' level of involvement in care and decision making, social and emotional support, access to information and education and concerns over the level to which rehabilitation programmes were tailored to meet individual needs. Additionally, serious concerns with access to appropriate and sufficient services were uncovered.

Each of these areas provides firm evidence of a need for the client and carer to be at the heart of the rehabilitation process. At a macro level, this reinforces the importance of adopting a social model of rehabilitation, aimed at enabling independent living of the client within his or her own environment. At a micro level, this needs to be translated into providing active and maintenance rehabilitation (Young et al., 1999) tailored to the self-defined and negotiated needs of the client. Moreover, the client, and carer as appropriate, should be enabled to be an active and equal partner in rehabilitation care.

However, attempts to achieve these aims were problematic in some settings. While a holistic model of rehabilitation was espoused, much of rehabilitation practice centred on *'the achievable'* rather than the ideal. Practitioners worked within ongoing organisational constraints, which inevitably lead to erosion of any broader philosophical beliefs about rehabilitation that they might hold. More often than not, care was service driven, as opposed to being individualised to the particular client. Practitioners focused on physical abilities and goals that were likely to be achieved within the current service structures.

When clients with a stroke on acute wards had 'no potential' for rehabilitation (in the physical sense), transfer to a rehabilitation ward was precluded. Improvements in physical function were not deemed possible. Even when the clients' cognitive abilities were unaffected, other rehabilitative options did not exist. Attention was not paid to the longer-term needs of the client, for example, in relation to role fulfilment, or ways to enhance quality of life. Another example comes from the work of the OT. This consisted of washing and dressing assessments, home visits and practising bed-to-chair-to-commode transfers with clients. These were the short-term 'achievables' that would enable clients to be discharged from hospital, preferably

into their own homes. Wider interest in cognitive and perceptual work and in enabling people to re-enter and gain fulfilment from their previous lives was an unexplored ideal.

Many (but not all) members of the multiprofessional team recognised gaps in their current service provision. The means to meet these gaps were not always clear to them. Nurses recognised areas of their role and contribution that could be developed with a view to enhance the client's experience and outcome of rehabilitation. Table 14.1 provides a summary overview, across case study areas, of the desired role of the nurse from the perspectives of the nurse and other team members, juxtaposed against the needs and expectations of clients and carers.

From the nurses' perspective, there were three main themes:

- more time to take forward their perceived role in rehabilitation
- greater knowledge and skills
- better teamworking.

This was consistent with the perspectives of other team members and would by implication meet many of the expectations and needs of clients and carers.

Some nurses and other team members saw a possible and beneficial role for a generic support worker. This often arose in relation to discussions about the need to reinforce the work of therapy staff. Generic workers could be a bridge between the very discrete and time-limited periods of therapist-provided 'treatment' and the 24-hours-a-day, seven-day-a-week care needs of the client. Free from the constraints of professional roles, generic support workers would be able to move between nursing and therapy teams, incorporating skills from both professional domains into their work.

While nurses should be supported in developing their role, in order for nurses to achieve some of these desirables, a number of issues would need to be addressed.

14.6.1 Organisational constraints

The wider organisational structures within which nurses work have an impact on the provision of rehabilitation care. In many cases, these organisational structures were found to be a hindrance to the provision of rehabilitation. For example, rehabilitation as a specialty was not always recognised, valued or prioritised at management level.

This neglect was perceived to manifest itself through staffing shortages, both nursing and therapy, with major consequences for working rehabilitatively. This was associated with a failure to address differences in the various professionals' shift patterns, and particularly the 'Monday-to-Friday' nature of therapy services. As not all team members can be present all of the time, it may be more relevant to identify the core skills that should be shared by all team members.

Insufficient numbers of therapy staff have implications across the acute, rehabilitation, community and continuing care sector. Without adequate input from core members of the rehabilitation team, nurses felt less able to meet rehabilitation needs. Indeed, outside designated rehabilitation settings, nurses felt unsupported in their role in rehabilitation. If nurses are to contribute to rehabilitation across the continuum of care, support must be provided in all settings, including nursing homes (Nazarko, 1994).

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Desired role of the nurse from the perspectives of the:		Expectations/needs of clients and carers
Nurse	**Multiprofessional team**	
More time for: o emotional care o involving families o activities o therapy integration and carry-on o linking with the community	**Greater involvement in:** o emotional care o client education	**Need for:** o more individualised care and emotional support o more information o more education o better quality of life at home
More skills and knowledge to 'do rehabilitation' In *fractured neck of femur and stroke*: o moving/handling o gait, mobility o washing and dressing o speech and language o continence o assessment skill In *rheumatoid arthritis*: o joint protection o pain management o counselling skills o coping strategies o sexuality o complementary therapies o assessment skills	**Nurse to have more skills** for therapy integration and carry-on, especially: o normal movement o moving and handling o speech and language o use of equipment o joint protection o washing and dressing o rehabilitation principles o assessment and goal setting	**Need for:** o more therapy o more treatment time o more consistency o less boredom
Better teamworking o recognition o skill mix o consistent skills base o sharing of skills o linking with community	**Better teamworking** o time to share skills o more therapy staff o nurses to have more time	**Better service provision** o community services o follow up o specialists o aids and adaptations

Table 14.1: Desired role of the nurse

Resourcing, organisational and staffing constraints undoubtedly impacted on client care. Indeed, these constraints may partly account for observations of staff exhibiting resentment while caring for clients or being patronising, insensitive or harsh, rather than demonstrating respect for their partners in care. For example, a nursing auxiliary snapped in front of a client who needed hoisting: *'If I have to do any more lifting, I'll have no back left'*. Other clients pointed to an ageist attitude. Mr Opal, a rheumatoid arthritis client commented: *'There are old people over there who deserve all the dignity and everything that goes with it, and ... from some people they don't get it'*.

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14.6.2 Teamworking

Role blurring compromised teamworking. Role blurring resulted from the need for a more consistent skills base throughout the rehabilitation team in order to best meet the client's rehabilitation needs. With the desire for skill sharing come issues of professional rivalry, protectionism and questions of equality within teams. Gibbon (1999) has also noted this in stroke rehabilitation settings. Closer teamworking and shared goals were required if the clients' needs, rather than the professionals' needs, were to be met.

As Anderson (1998) noted, it is essential within teams that all members wish to collaborate and assist each other. This will only occur if each member feels equally valued within the team. In this research, the emphasis on skill sharing lay on members of nursing and support staff combining aspects of 'therapy work' into their current role.

14.6.3 Recognising the nursing role

Exploring the dynamics of rehabilitation teams highlights the need for nurses to be recognised by others and for nurses themselves to recognise, value and feel more confident in their knowledge and skills. Changes in perceptions within and beyond the nursing profession are required.

Many of the nurses felt that the nursing profession ascribed rehabilitation with the negative connotations associated with caring for older people. In the acute and community settings, many nurses equated rehabilitation with the expert therapy provider, for example, 'intensive' physiotherapy, paying scant recognition of the nursing contribution. As Young et al. (1999) have commented, it is debatable whether more 'therapy' itself leads to better outcomes. It is rather the philosophy of therapy and interdisciplinary working that is essential.

Some nurses did not appear to understand how the nurse fitted into rehabilitation. Rehabilitation was compartmentalised as a separate entity to nursing, commonly associated with a time (*'no time'*), a place (*'down to rehab. gym'*) or person (the physiotherapist). Some saw the therapy role as co-ordinating with the therapist as expert, while others felt hands-on involvement in therapy should be formalised. Moreover, full involvement in therapy integration and therapy carry-on depended on personal motivation (cf. Waters and Luker, 1996).

14.7 Conclusion

The comparative analysis has provided insight into and understanding of the role and contribution of nurses in their practice within the multiprofessional rehabilitation team. In essence, it can be characterised as an emphasis on *'the achievable'*. While it is evident that some, if not all, nurses espouse a broad conception of rehabilitation, the extent to which they are able to integrate therapy into their care delivery is more variable. What is achievable is dependent not least on the realities of running a busy ward or working in relative isolation in the community, skill mix, and staff shortages (of both therapy and nursing staff). It is also dependent on others' valuing the nurse's role and contribution (the notion of reciprocity) and role blurring at the boundaries, along with the knowledge and skills possessed by staff. Finally, and by no means least important, the nurse's role may be restricted by client and carer expectations.

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Key points

- Only 36% of respondents to the postal questionnaire (57% response rate) thought that their pre-registration education had provided them with adequate skills and knowledge for their role in rehabilitation. A lack of focus on rehabilitation and on the necessary clinical skills was noted.
- Most nurses (71%) had attended an educational or training course relevant to their role in rehabilitation in the last five years. Over half (58%) would like to attend other such courses or study days. There were difficulties in attending relevant courses, ranging from staffing problems on the ward, a perceived lack of relevant courses and funding.
- A variety of other methods for keeping up to date and learning about rehabilitation were mentioned, in particular: in-service training, learning by experience and from colleagues, reading journals, membership of practice associations or specialists groups, and doing projects to develop practice.
- Nearly two-thirds of respondents (65%) indicated areas of their current role in rehabilitation they would like to change or learn about. Areas of change ranged from developing the nurse's role, having more time/staff and playing a greater role in the team. Perceived learning needs related to more understanding of the specific clinical conditions, the whole process of rehabilitation, the contribution of other team members, wider care outside the hospital, psychological care and pain management.
- Better education would lead to better client care. Enhanced confidence was noted, and a need for a consistent skills base throughout the nursing team.
- Therapists identified gaps in nursing knowledge and skills covering their ability to carry on the work of therapists and nursing care being informed by the philosophy and principles of rehabilitation. The emphasis was on the nurse learning from the therapist.

This chapter moves the analysis on a stage further by presenting findings on the relevance of pre- and post-registration education in preparing the nurse for her role within rehabilitation. It provides a bridge to the subsequent analysis and discussion in Chapter 16 on the implications of the study's findings for nursing education. The chapter begins with a brief overview of the characteristics of the respondents to the postal questionnaire. It then examines how prepared they were for their role within the rehabilitation team from pre- and post-registration education, other ways that the nurse learned and kept up to date and their and others' perceptions of learning needs.

The findings are drawn from two main sources. First, as part of the fieldwork within each of the case studies, the views of key nurse informants were sought as part of wider interviews relating to the rehabilitation of particular clients. Second, in order to ensure systematic coverage of issues relating to the nurses' rehabilitation education, practice development and the skills and knowledge required, a postal questionnaire was designed and delivered to qualified nurses working in all locations where clients had been recruited and/or observational and interview data gathered.

15.1 The postal questionnaire respondents

Of the 240 questionnaires delivered to the ward areas, 137 were returned, a response rate of 57%. D- or E-grade nurses represented 70% of the sample, with a further 27% being at junior/senior sister level (F and G grade). Each had been a qualified nurse for a median of

12 years (a mean of 14.3). Respondents covered the range of studied locations, embracing the more specialist rehabilitation settings as well as the more generalist condition areas and community nursing.

15.2 Pre-registration education

Only 36% of the nurses who responded to the questionnaire thought that their pre-registration education had provided them with adequate skills and knowledge for their role in rehabilitation. Those working in the community thought they were best prepared (55%), compared to about a third in other areas, except rheumatology where it was as low as 10%. Only a quarter of those qualified for less than two years indicated that they were adequately prepared. Notable problem areas included a lack of focus on rehabilitation and the clinical skills needed in the area (Table 15.1).

Problem area and examples	Number
Education on rehabilitation: in general (19), conditions requiring rehabilitation (seven), theory and philosophy behind rehabilitation, ageing process	36
Education for clinical skills: manual handling (nine), lack of clinical placement (eight), lack of 'hands-on' skills (eight), goal setting and assessment, mobility and gait, dysphasia, incontinence	35
Teamwork: lack of emphasis on multiprofessional teamwork (14), communication within the team	18
Dominance of acute care model: too little emphasis on chronic illness disability and long-term care (seven), discharge planning, involving the family, support services in the community	14
Psychological care: counselling (five), communicating and motivating the client, behavioural problems	10

Note: Respondents could mention more than one area of lack.

Table 15.1: Problem areas of pre-registration education for rehabilitation role

These perceptions were consistent with the interview data. Pre-registration education was felt to provide only a very basic introduction to rehabilitation, in contrast to acute nursing care, for which it provided a good background and preparation. Particular problem areas were a lack of preparation in relation to the nurse's co-ordinating role in rehabilitation, multiprofessional teamwork itself and broader condition-related matters, in particular, the impact of multiple pathology and care in the community.

Nurses noted that students who came to rehabilitation wards were already in the acute mind-set of 'doing for'. They struggled to adapt to the rehabilitation philosophy:

> **Interviewer:** *'Do you think that when students come here they have a concept of what rehabilitation's all about?'*
>
> **Respondent:** *'Not a thing. As I say, I think the concept still is nurses are doers and they've found it very hard to stand back and let someone try and do something for themselves. They can see them [the clients] struggling a little bit and, "Oh, well, I'll go and help them" and in the long term that doesn't help the patients. So I think they're still in the mode of nurses as doers and they find it very hard and difficult to stand back and let somebody do it themselves.'*

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Methods for keeping up to date in rehabilitation included:

- courses and study days
- in-service training
- learning from others.

15.3.1 Courses and study days

A total of 97 respondents (71%) indicated that they had attended an educational or training course relevant to their role in rehabilitation in the last five years. These included ENB courses (23%) – for example, course number 998, *Teaching and assessing in clinical practice for nurses* (17 people – although not directly related to rehabilitation), course number 219, *Orthopaedic nursing* (six people) and course number 928, *Diabetic nursing* (three people); in-service training (23%) of which some was multiprofessional; and conversions, degrees, diplomas or masters programmes (9%).

More than half of respondents (58%) would like to attend other courses or study days that related to their role in rehabilitation. These included 79% of those working in general rehabilitation, 63% in acute or rehabilitation for strokes, and 27% for community staff. While there was no significant difference by years since qualifying, a higher proportion (67-71%) of the recently qualified (less than two years as a nurse) and those qualified for a long time (16 years or more) wanted to attend other courses or study days than those qualified three–five, six–ten or 11–16 years (47-55%).

Respondents referred to a wide range of courses. These varied from 'any' rehabilitation course (14 people) to specific courses (24 courses mentioned by a total of 49 people). The latter focused either on a disease (six courses by 14 people – for example, stroke, diabetes, multiple sclerosis or neurology in general), clinical skills (11 courses by 22 people – for example, continence, dysphasia, intra-articular injections, leg ulcer, pain management, care of the dying), or wider educational skills (seven courses by 11 people – for example, teaching, clinical supervision and instruction with the physiotherapist).

Staff had encountered a number of difficulties in attending relevant courses. Of the 81 who commented, foremost was their being unable to attend due to staffing problems on the ward (33%), followed by a perceived lack of relevant courses (21%) and funding difficulties (15%), either a lack of funding or the course being too expensive.

In interview, nurses commented that rehabilitation-focused courses were a good way to deliver theoretical and clinical knowledge and to provide professional recognition of the specialist skills that rehabilitation nurses felt they possessed. The latter was seen as an important way of improving promotional prospects within rehabilitation, where nurses had to compete with physiotherapists and OTs for managerial posts. Formal qualifications were also seen by some nurses as a way of fostering equality between nurses and therapists working together within rehabilitation teams.

However, there was a lack of courses perceived as relevant to the nurse's role in rehabilitation. This was compounded by the fact that courses that were available were often long distances away. This posed difficulties getting study time away from work.

15.3.2 In-service training

Nurse interviewees drew attention to the importance of in-service training as a means of learning. This was particularly relevant for learning about the roles of other team members and for developing hands-on skills. However, it was usually the first activity to *'fall by the wayside'* in times of staff shortage, sickness and increased workload. In some areas, although

rolling in-service training programmes had been devised, these had not functioned for several months due to staffing and workload difficulties.

On-ward learning resources were well developed in some areas, notably the specialist rehabilitation units (the young people' disabled unit and stroke unit). Educational resource folders on rehabilitation, grief and bereavement, stroke care and bowel and bladder care proved a useful reference source for practising nurses and students on placement on the wards.

Link nurses also acted as a valued resource for other nurses and team members. They provided a source of advice on current best practices, recent innovations and could cascade research information to the rest of the team.

Some wards were trying to develop better learning resources specifically for student nurses. However, from observation of practice, it was evident that opportunities for teaching students were not always taken and students did not always recognise the value of their rehabilitation placements.

15.3.3 Learning from others

'Learning by experience' and *'picking things up as you go along'* were the most frequently mentioned sources of post-registration education in the nurse interviews. This involved asking questions based around client care, being self-motivated and learning from other team members, such as more senior nurses, the physiotherapist, speech and language therapist and OT. In addition, nurses commented that learning was a continuous process: *'I've been working in the day hospital with the physio and OT for some years now, so I've learnt from them'* (Staff nurse).

However, learning from others was in general an *ad hoc* process. It depended significantly on the personalities of other team members and the motivation of the individual nurse. Sometimes, learning from others was very difficult due to the team structure, working practices and attitudes. For example, one nursing auxiliary expressed her dissatisfaction with the practices on her ward:

> *'When I worked on this other rehabilitation ward, we [the auxiliaries] worked with the physio and followed patients through to the gym so we could learn what was going on. It was much better.'*

Learning from others did not usually involve being deliberately instructed in a one-to-one session, but usually involved opportunistic observation:

> *'I've never been shown. I've observed physios doing ... You pick things up from them and if you need any advice, but it's experience definitely ... You're learning from others.'* (Staff nurse)

However, some nurses felt that they were only now, after years of experience, beginning to learn properly about rehabilitation. Due to the inadequacies of *ad hoc* learning, *'we [have only now] found out that we've been doing things wrong, for so long'*. Others commented that improvements in practice had not occurred because *'nurses here don't keep up with the times – they're doing things they learnt 20 years ago'* (Staff nurse). The reliance on self-motivation and personal interest to prompt continuous education and development meant that some practitioners stagnated.

15.4 Other activities enhancing professional practice and learning

Attending courses and asking colleagues were not the only ways that staff members kept up to date or enhanced their skills and knowledge. Reading journals was frequently mentioned. A few of the interviewed nurses specifically mentioned Stroke Association conferences where they valued hearing the personal accounts of stroke survivors. They also mentioned membership of practice associations, specialist groups and undertaking research.

15.4.1 Practice-related associations and research

Just over a third of questionnaire respondents (35%) were members of a practice-related association or specialist group. Those working in rheumatology (70%) or the community (50%) were much more likely to belong to an association or group than those working in either stroke, orthopaedic or general rehabilitation (24-36%). About a half of those who had been qualified for six–ten years, or 21 years or more, were members of such groups. The types of groups varied from the RCN or other forum (16 people – for example, rehabilitation, rheumatology, neuro-science, multiple sclerosis) to specialist interest groups for continence (11), wound care or tissue viability (six), infection control (four) or other areas (19 people – for example, care of older people, pain, social therapy, nutrition), and management-related groups (15 people – for example, health and safety, professional practice, research).

Nearly half of the nurses (48%) had been closely involved in practice-related research, audit or other projects introducing new practices (Table 15.2). Those working in rheumatology or the community were most likely to have done so (59-60%) and those working in general rehabilitation least likely (33%). As might be expected, those who had qualified in the last two years were least likely to have been involved (22%), and those qualified from 16-25 years most likely (59-61%).

Topic area and examples	Number
Developing nursing: team changes, primary nursing, nurse-led clinics, home visits, named nurse, skill mix, nursing model for rehabilitation	13
Communication: discharge documentation, taped hand over, care plan, multidisciplinary team documentation, admissions	12
Developing practice: patient clinic, carer involvement, drug trial, second-line referral, patient information booklet	12
Service quality and standards: rheumatology, stroke, referrals for rehabilitation, risk assessment	12
Wound care and pressure sores	9
Medication: self-medication, discretionary drugs policy	6
Coronary heart disease: secondary prevention	5
Education: wound care, student induction	4
Other: nutrition, recreational therapy, pain, moving and handling, teamwork	9

Table 15.2: Topic areas of projects

15.4.2 Developing practice

While difficulties in changing practices and long-established routines were noted by a number of nurses, there were examples of good practice where rehabilitation managers had identified problems with their service and had endeavoured to rectify them (Table 15.3).

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o Introduction of the Orem model of nursing	o Development of the role of the night nurse/night staff
o Introduction of new documentation	o Development of the 'care pathway'
o Introduction of multiprofessional team (shared) notes	o Nurse-led evening clinics
o Audit of referrals to rehabilitation ward	o Sexuality self-help groups
o Introduction of therapeutic activities/ social therapy	o Strategies to increase carer involvement
o Patient self-medication	o Client-centred goals – with therapists
o The introduction of standardised outcome measures – for example, the Barthel Index, the Therapy Outcome Measure	o Introduction of a tool to measure patient dependency levels and skill mix requirements
o Therapeutic handling	o Use of a pain assessment tool

Table 15.3: Areas of practice development

In one rehabilitation unit, in response to client and carer complaints on poor moving and handling practices, nurses and physiotherapists worked together to improve the standard, via appropriate training and assessment of skills acquisition. Further analysis of their service provision revealed other areas for improvement, such as staff communication skills and limited client activities. In identifying problems with the service and contributing factors, the rehabilitation team as a whole was able to begin to tackle these issues, with consequent beneficial effects on the client's experience and care.

Another example relates to students. A number of nurses pointed to student nurses as being an important motivator for practice development. Units striving for student access were clearly attempting to improve the learning resources and opportunities available for students, and improving their practice at the same time.

15.5 Perceived learning needs in relation to rehabilitation

Nearly two-thirds (65%) of the postal questionnaire respondents drew attention to aspects of their current role in rehabilitation that they would like to change or learn more about. Nurses working in a general rehabilitation area were most keen for change or additional learning (86%). This compared to 42% working in the orthopaedic area. Those recently qualified were similarly keen for change (86%) followed closely by those who had been qualified for six–ten years or 21 years or more (73-78%).

Five main areas of change were identified:

- developing the nurse's role
- having more time and staff
- having a greater role in the multiprofessional team
- providing improved services
- better teamwork.

15.5.1 Developing the nurse's role

Identified by 12 respondents, this covered areas such as:

- greater involvement with those in chronic pain
- setting up self-help support groups

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- conducting group-work sessions for client education or setting up education classes on the disease and rehabilitation
- getting out and about with clients post-discharge
- developing district nurse involvement with the hospital to aid the client's transition to their own home
- developing the primary nurse to enable a greater involvement in rehabilitation rather than, as at present, just to get through the workload
- assessing suitability for rehabilitation
- developing team documentation.

15.5.2 Having more time and staff

Identified to by eight respondents, this covered:

- the need for more therapy staff
- the need for therapy staff at weekends
- the nurse to have more time with the client
- the nurse to have time with the client to help mobilise or do passive exercises.

15.5.3 Having a greater role in the multiprofessional team

Mentioned by six respondents, this included:

- becoming the main worker at the commencement of rehabilitation
- being more self-sufficient, for example, nurse prescribing
- having a greater involvement in rehabilitation.

15.5.4 Providing improved services

Five of the nurses identified a range of specific changes:

- dedicated rehabilitation beds for those with fractured neck of femur
- better liaison between hospital and community services
- formation of a community rehabilitation team
- the need for greater primary care support for clients.

15.5.5 Better teamwork

Two respondents noted this issue.

15.5.6 Knowledge and skills

In terms of knowledge and skills a range of areas were identified (Table 15.4). While the nurses once again pointed to a need for more understanding about the specific conditions, there was substantial interest in knowing more about the whole process of rehabilitation, the contribution of the physiotherapist and OT and the wider care and rehabilitation provided outside the hospital setting. Psychological care and pain management also feature prominently. Finally, it is significant that some of the nurses made reference to their need to know the research evidence base for their work.

Topic area and examples	Number
Specific conditions: neurology, stroke, effects of stroke in the longer term, ageing process, older person's needs, continence, speech, swallowing	17
The whole process of rehabilitation: know more about every aspect, principles of rehabilitation, more up-dating	12
Care in the community: social services, social work, after care, role of the continuing care team, support agencies, client's experience in the community, relative's role in rehabilitation, knowledge for a systematic approach to rehabilitation in the client's home	12
Physiotherapy and occupational therapy: more knowledge (mobility, exercises, their role, their skills), more time with OT and physiotherapist, work with OT and physiotherapist	11
Psychology and behaviour: all aspects, altered body image, behaviour modification, counselling	6
Pain and analgesia: pain perception, administrating medicines, drug monitoring	5
Research: research evidence for what we do and to confirm what we are doing is in the client's interest	3
Visit other centres: local and national networking, what they are doing compared with what we are doing	3
Maintaining client independence: how to maintain, how to promote	2

Table 15.4: Areas nurses want to learn more about

15.6 Required knowledge and skills for rehabilitation role

The nurses thought that there needed to be a greater focus on rehabilitation in both pre- and post-registration education.

15.6.1 Pre-registration

At the pre-registration level, the interviewed nurses felt that rehabilitation should be developed as a specialty within the pre-registration curriculum, upon which further post-registration education could then build. They commented that newly-trained nurses working in rehabilitation needed specialist skills which pre-registration education did not provide. As such, new nurses coming in to rehabilitation needed a 'development plan' to help them to attain these specialist skills.

One possibility was that all students should have a rehabilitation placement to equip them with the skills, knowledge and confidence to function within the rehabilitation setting. Ideally, it was felt the student's placement would involve spending time with therapy staff. Indeed, nurses working in all areas of health care, including acute settings, were perceived as needing to possess rehabilitation skills.

15.6.2 Post-registration

It was at the post-registration level that informants perceived 'rehabilitation nurses' to be made.

> *'Rehabilitation, especially in elderly care is very complex. I don't know if you could learn it in pre-reg. I think it's a post-reg. speciality.'* (Sister)

In particular, there was a feeling that there was a need for better access to specific, certificated courses to enable nurses to participate more fully in the rehabilitation process, particularly in the assessment of clients' abilities, assessing the potential for rehabilitation and

progress towards treatment goals. Nurses also wanted to be more knowledgeable in order to integrate and carry on therapy and thus provide nursing care informed by the philosophy and principles of rehabilitation.

There was also an interest in multiprofessional education. Learning from and with each other was seen as essential in rehabilitation, fostering shared skills and approaches to working. Not only would this enhance team members' understanding of each other's role, but it would also offer the opportunity for therapy staff to learn from nurses (and *vice versa*).

> *'I think it's educating each other that we can cross over because I've worked on a stroke unit where ... it was wonderful and I've also worked in neuro rehabilitation, you know head injuries and things, and it was very much that we all mucked in together. OTs would go in and help patients with showering and the physio would help with toileting. So I find it quite bizarre that people don't cross over.'* (Sister)

> *'I think that when people do ... the training for the OT ... I think it would be a useful thing to perhaps amalgamate for certain sessions and get a real feel for rehabilitation, because I think rehabilitation goes across the board of all care anyway.'* (Staff nurse)

15.6.3 Specific areas of need

A wide range of areas of interest for further education and training were identified. Analysis of the questionnaire responses to an open-ended question on perceptions of the skills and knowledge the qualified nurse needs in order to fulfil their role in rehabilitation identified a number of thematic areas:

- contributing to meeting physical needs
- the nurse's contribution to teamworking
- the nursing approach
- personal characteristics of the nurse
- general care planning and delivery
- contributing to psychological care.

Contributing to meeting physical needs

Identified by 12 people, this related to two different areas:

- the nurse as care provider, covering aspects such as wound and pressure area care, continence, medication, prevention of complications and giving hands-on care
- the nurse's contribution to rehabilitation, in particular, the need to carry on, moving and handling, positioning, nutrition and exercise and mobility.

The nurse's contribution to teamworking

This was identified by 10 respondents. Nurses needed good skills in teamworking, liaison, communication, organising and managing people, mediating, negotiating and diplomacy. They also needed knowledge of other disciplines and their role within the team, knowledge of other agencies and support services, knowledge of who to refer to and when. A nurse should be a teacher, a good observer, information collator and documentor.

The nursing approach

Identified by nine people, key elements included: being holistic, providing individualised care, promoting independence, providing education, supporting and valuing clients and their families, being an advocate and empowering clients.

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Six people drew attention to the nurse's need to have problem-solving abilities, a questioning mind, humour, confidence, patience and time to work with a small group of patients.

General care planning and delivery

Identified by four people, this embraced assessment skills about the client's potential for rehabilitation, their limitations and abilities, planning care, setting and evaluating goals and discharge planning.

Contributing to psychological care

Identified by four people, this included general psychological care, empathy, caring and compassion, listening skills and counselling.

In addition, 12 respondents noted more specific areas of knowledge and skills. These included greater knowledge about the physiology of the condition/specialty area, along with a need for greater understanding of the philosophy, theory and clinical practice of rehabilitation. Again, there was reference to the width of the necessary knowledge base, to include, for example, knowledge of disability, handicap and their consequences, the needs of the elderly, social care and the client in the community.

15.7 The benefits of education – meeting the gaps

At one level, better education would lead to better client care: *'If nurses were trained adequately to maintain this continuity role then it would make a big difference'*. Greater practical and theoretical knowledge was needed for staff nurses and support workers in order to ensure this continuity:

> *'... with stroke care, there is a lot of practical ... activities that we have to deal with which you could teach anybody to do. But you need the theory behind it to know why you're doing it. When they're getting washed and dressed in a morning you always put their affected arm in first and people sort of say, "Well, why?" You know ... you need to have that knowledge.'*
> (Staff nurse)

Nurses also drew attention to the effects of confidence in undertaking their role in rehabilitation, the need for a consistent skills base within nursing and the leadership role in the care setting. Each will be considered in turn.

15.7.1 Confidence

Many nurses felt that they lacked the necessary underpinning knowledge to confidently fulfil their role in rehabilitation. This lack of confidence was more marked in general as opposed to specialist rehabilitation units. Nurses working on general rehabilitation units had often had to adapt their practice from working in an acute or medical setting following a service reorganisation. This transition might or might not be accompanied by further education and training.

Greater confidence in their skills was needed so that the nurse could be more assertive about client care. Nurses commented that they wanted to be able to say: *'Yes, we can aim for that,'* or *'They should be able to go home'*. They wanted to be more able and more confident to make independent decisions about client care. This lack of confidence was interconnected to a perception of some nurses that therapy staff had little faith in the nurse's ability to make client assessments: *'Often the therapists don't trust the nurse's assessment'*. Again, it was felt that further education and training would equip them with the confidence in their skills to enable them to work more equally with therapy staff.

15.7.2 Consistent skills base throughout the nursing team

Nurses identified gaps in the knowledge and skills base within the nursing team. Members of the night staff were seen by day staff to be disadvantaged in that they had little contact with other therapy members of the team. One consequence was that members of the night staff were less able to develop rehabilitative skills. This had an impact on the consistency of care provided and success in working towards rehabilitative goals.

The observational and interview data also indicated that support workers and auxiliaries would benefit from education and training, especially as they provided a large amount of the client's physical care. This would overcome their tendency to 'do for', even in specialist areas. Problems with the moving and handling of clients were observed. Other members of the multiprofessional team had also noted this. Courses at NVQ level were cited by qualified nurses as a vital way of developing support workers. Some also saw a potential benefit for a generic rehabilitation support worker, who would possess skills from the occupational therapy and physiotherapy domains.

Finally, from the perspective of the nurse and of other team members, there was a recognised need for all team members to be educated in certain core skills. This would enable 'multiskilling' of all team members. The desire, shared by all team members, was for a higher level of skill throughout the team.

15.7.3 Leadership in the care setting

Good leadership within the care setting was viewed as essential in enabling nurses to develop and meet their educational needs. The leader did not have to be a nurse. Indeed, some nurses cited difficulties learning from senior nurses due to the small amount of hands-on care that the senior nurses delivered. Further, other senior nurses wanted guidance as to what they themselves should be achieving or doing on their rehabilitation ward.

At another level, some staff nurses noted that it was not always easy to develop practice and they felt held back by the nursing hierarchy:

> *'Once you try to foster learning, you can't always do it because it is seen as though you are stepping out of line. Or, if you wanted to learn or educate yourself, you know, it's, "You don't need to do things like that".'*
> (Staff nurse)

15.8 The perception of other team members

The therapy members of the multiprofessional team identified some gaps in the skills and knowledge of nurses. These were more pronounced in general rehabilitation settings. Indeed, within the specialist rehabilitation area, nurses were seen as possessing extra skills and knowledge. These lay in their ability to identify client problems early on, to refer appropriately, to organise initial treatment and care and to assess the effectiveness of therapy.

Gaps in the nurse's knowledge ranged from ways to carry on the therapist's work, to nursing being informed by the philosophy and principles of rehabilitation:

- thermal stimulation
- client handling and moving
- understanding cognitive problems
- swallowing problems and communication
- putting psychological care into practice
- rehabilitation approach
- anatomy and normal movement.

These knowledge and skill gaps were described as inhibiting the nurse's ability to be *'proactive in the rehabilitation process'* (Physiotherapist).

Team members saw it as part of their responsibility to share their skills with nurses, through in-service training sessions and one-to-one work with specific clients. But the therapists felt that their contribution was not always valued or taken on board. They also found it difficult to find time to set up education and training sessions in the context of staffing shortages (as they were frequently working below the required staffing quota), and/or to simply work together with the nurse. Nurses were also viewed as overstretched.

Reciprocal learning from nurses was infrequently mentioned. Some therapy staff members noted the potential benefits of multiprofessional education to promote better teamworking. However, the emphasis was more on the nurse learning from the therapist than *vice versa*. Indeed, at least within the hospital setting, there was little incentive to learn from nurses. Nurses and nursing work lacked scarcity value; they were always present on the ward.

15.9 Summary

A common theme throughout this and previous chapters has been evidence of the broadening role of the nurse in rehabilitation. Changes and developments within services have meant that nurses are being asked (and are also volunteering) to take on new roles and responsibilities. As this chapter has shown, nurses have responded to these challenges with the desire to understand the 'how' and 'why' of their new activities, rather than being satisfied with simply *'picking things up'*.

Both the interview and postal questionnaire data show nurses' perceptions of inadequacies in educational preparation (pre- and post-registration) for their current roles in rehabilitation. Informal, *ad hoc* learning on the job and a shortage of rehabilitation-specific courses have left many nurses with a sense that their skills and knowledge for rehabilitation compare poorly with those of the therapy staff. Nurses working in rehabilitation have clear ideas about specific learning needs and desired topics for continued education within rehabilitation. These include greater knowledge about clinical conditions, wider care in the community, psychological care and pain management, as well as an enhanced understanding of the principles and practice of rehabilitation. The challenge is to find the best way to meet these learning and developmental needs.

Key points

- The knowledge base required for effective nursing practice in rehabilitation is wide and complex.
- Specific skills, knowledge and competency areas can be identified for both pre- and post-registration education. These include:
  - awareness of the client and carer perspective
  - chronic disease
  - creating a therapeutic environment
  - listening and communication skills
  - motivational skills
  - normal ageing
  - rehabilitation in the community
  - risk assessment.
- Underlying all of the above is the essential need for the nurse to have a full understanding of the philosophy, principles and models which underpin rehabilitation, and the impact these have on service delivery and the client's experience of care.
- Within pre-registration education, rehabilitation should be an ongoing thread throughout the entire curriculum. Integration could mean invisibility and thus a dedicated module may be needed.
- At post-registration level, a nationally-recognised and accredited post-registration qualification in rehabilitation is perceived as essential. Post-registration courses should be multiprofessional, involving all team members and, where possible, medical staff.
- Learning in the workplace needs to be integrated with more formal educational provision. Organisational support and local facilitation is required to enable nurse participation, especially in multiprofessional team learning including multiprofessional journal clubs.
- Learning about rehabilitation also needs to be recognised and valued by managers. They need to understand the nurse's role therein and the implications for staffing levels and mixes.

This chapter summarises the implications of the study's findings for nursing education. It draws together data collected from within Phase 1 of the project (in particular, staff interviews and the postal questionnaire survey) and the discussions within the national expert workshops conducted in Phase 2. The implications are firmly based on the views and experience of contemporary clinical/service-based practitioners and educationalists. The discussion focuses on educational implications in relation to adult nursing. At the same time, it may have wider applicability to other branches and to professional education in other health and social care disciplines.

16.1 Previous research on the nurse's preparation for rehabilitation

Rehabilitation has been described as a Cinderella service, being less popular, less glamorous and less attractive than acute care. Similarly, education for nursing practice in

rehabilitation suffers from low status and relative neglect. Nolan et al. (1997b: 4), in their analysis of nursing curricula for rehabilitation, concluded that:

> *'The current educational preparation of nurses, whether at pre- or post-registration levels, generally fails to prepare practitioners to play a more prominent role in rehabilitation.'*

With only a few exceptions, they continued, curricula for all courses failed to explore in a systematic way issues related to chronic illness or to the generic or specific nursing role within rehabilitation.

> *'Education would appear to do little to prepare nurses to play a more proactive and holistic part [in current rehabilitation practice]'* (*ibid.*: 4)

As Chapter 15 demonstrated, the perceptions of the participants in this study concur with these conclusions.

16.2 Developing professional knowledge and skills

The knowledge and skills base for effective nursing practice in rehabilitation is wide. While the context and level of practice are important, participants at the national expert workshops identified some core skills, knowledge and attributes which emerged as essential to the nurse's role in rehabilitation (Table 16.1). These areas apply to both pre- and post-registration education. They suggest an incremental development of knowledge and skills, and an increasing complexity in their application along a continuum of practice from cadet nurse to nursing in a specialised rehabilitation context and in the community.

Rehabilitation skills are essential in all areas of health care, not only those with a specific label of 'rehabilitation'. Two simple examples are skills for normal movement and motivation. Workshop participants noted that some of the skills needed for rehabilitation may be *'buried in the content of essential and basic care'*. By 'buried' it was meant that areas of skills and knowledge may be covered in the curriculum and nursing attachments, but may not be recognised as being rehabilitative.

o advocacy	o listening and communication skills
o awareness of the client and carer perspective	o motivational skills
o assessment skills	o negotiation
o change management (personal and organisational)	o normal ageing, the effects of pathology, and social and psychological changes
o chronic disease, disability and multiple pathology	o organisation of health and social care
o creating a therapeutic environment	o problem solving
o empowerment	o rehabilitation in the community
o ethics and moral decision making	o risk assessment
o health education and promotion	o supervisory skills
o information giving	o teamworking
	o use of technology
	o working with the voluntary sector

Table 16.1: Skills, knowledge and competency areas for pre- and post-registration education

16.2.1 Understanding the philosophy and principles of rehabilitation

Underpinning all the above is the essential need for the nurse to have a full understanding of the philosophy, principles and models which underpin rehabilitation, and the impact these have on service delivery and the client's experience of care. Nursing education

for rehabilitation should be founded on a social model of rehabilitation, which recognises its role within health and wellness, as well as in disability and illness, and prioritises the client and carer perspective.

16.2.2 Working in teams

Working in teams is fundamental to rehabilitation practice and should be the core of all rehabilitation education. Each team member needs understanding of the knowledge and skills of others, valuing others' skills and potential contributions, along with seeing how all members can work together for the client's benefit.

The development of a shared language and philosophy has consequences for the client experience. A shared understanding of the nature and purpose of rehabilitation would enable more effective, collaborative assessment, goal setting, care planning and evaluation, consistent care delivery. It would also make explicit the roles of team members. Many of the problems clients and carers have identified are related to conflicting information and advice, which again may relate to unrecognised contradictions in the perspectives of professional groups.

16.2.3 The client as the focus

It is important that there is a structure for educational programme development and delivery that enables client participation and ensures that the voices of the client and carer are heard (Taylor, 1998). Education and training must be sensitive to the diversity of clients in terms of, for example, culture, race, ethnicity, gender and age.

16.2.4 Valuing the nurse's contribution

Underpinning these specific components for nursing education in rehabilitation is a need to highlight the role and contribution that the nurse can and should make. Workshop participants identified this need, not just for students but also for their teachers both in the academic institution and in the clinical setting. In this context, the potentiality of nurse consultants in rehabilitation was important, as such posts could raise the profile of rehabilitation nursing, and offset the seeming lack of self-esteem, confidence and assertiveness of nurses working in some (usually non-specialist) rehabilitative settings. More widely, there was a perception at the national expert workshops that many nurses felt less knowledgeable about rehabilitation than therapists. The therapists' entire training was seen to be *'about rehabilitation'*.

16.3 Specific implications for pre-registration education

Nurses and other health care professionals saw pre-registration education as being dominated by an acute care and medical model. Rehabilitation needed a higher profile and clearer focus. At the educationalists' workshop, it was suggested that some nurse teachers may lack the specialised knowledge, skill and experience needed to deliver material on rehabilitation in a meaningful, practice-based way. This may be mirrored in the clinical setting. Where the teachers had a particular interest, rehabilitation received more coverage. This is consistent with Mhaolrúnaigh et al. (1996), who reported the need for teachers to be skilled in working with students in shared learning.

Within the theoretical component, rehabilitation should be integrated into nursing education for all clients. The most common model advocated by informants at the national expert workshops was described as a *'thread and module'* approach, that is, an ongoing theme throughout the entire curriculum. At the same time, there is a danger that integration could equal invisibility. A specific module or other form of dedicated content may be necessary. Central is the need for explicit learning objectives related to rehabilitation, both within the academic institution and the clinical setting. Within this, a client-focused or scenario-based

approach would be an appropriate vehicle for learning theory, with the proviso that the material be clinically relevant and illustrate the contribution of the nurse and benefits for the client.

Against the generality of Table 16.1, attention can be drawn to a number of specific knowledge and skill areas:

- better development of practice skills, especially 'hands-off' skills (integrating, coaching, educating, listening and communicating) and moving and handling
- greater focus on the emotional and psychological care of clients and carers
- increased knowledge of relevant physiology and pathology especially related to chronic health problems, multiple pathology and normal ageing
- increased understanding of the psychological and social impact of long-term health problems, impairment and disability
- preparation for a role in teamwork, especially activities related to the co-ordinator/communicator and advocacy role.

Student placement has a critical role to play. Some participants at the national expert workshops argued that all students should undertake a dedicated rehabilitation placement. However, changes in provision must take heed of the apparent negative student valuation of rehabilitation placements. The research informants' perceptions was that students seemed to see them as areas to develop 'basic' nursing skills, finding it hard to identify learning specific to rehabilitation.

Students can learn about rehabilitation in almost all adult nursing settings. This requires explicit rehabilitation-specific learning objectives.

Placements must also be of sufficient duration for students to see the outcomes of rehabilitative care. In this regard, a student might then usefully follow a client through part of their rehabilitative pathway and/or more extensively across the continuum of care (perhaps in the form of a *'virtual client'*).

Explicit learning objectives are important both within the educational institution and the ward/practice setting. Student mentors and assessors may require assistance to identify the rehabilitation skills and the rehabilitative nature of the nurse's work. This also raises the issue of the importance of positive role models and the potentially important role to be played by the link teacher.

In summary, the end point of pre-registration should be nurses who can work effectively in rehabilitation settings. They need to be able to identify their learning needs and go on to develop specific, specialist rehabilitation skills at post-registration level. It may also be appropriate that generic themes, such as communication, co-ordinating care and problem solving, are taught interprofessionally.

16.4 Specific implications for post-registration education

Post-registration education in the area of rehabilitation should build on adequate pre-registration exposure. Continuing professional development is a vehicle to empower nurses working in rehabilitation by demonstrating that they operate on an equal footing with other team members.

Both practitioners in Phase 1 and participants in the national expert workshops (Phase 2) concurred that current post-registration course provision was too fragmented and focused on assignments, rather than competencies and developing hands-on skills. Many nurses went on non-specific post-registration courses and then tried to *'adapt'* them to suit rehabilitation. As a result, sometimes the nurse's post-registration learning was to a greater extent informal, where possible picking up skills from other nurses and/or therapists.

Against this background, a nationally-recognised and accredited post-registration qualification in rehabilitation was perceived as essential. Moreover, there was overwhelming support for post-registration courses to be multiprofessional, involving all team members and, where possible, medical staff. Such multiprofessional education could help to develop a common language among health care practitioners, and a common definition and understanding of rehabilitation. This would incorporate care, maintenance, empowerment, coping, user involvement and rehabilitation in the community. Finally, rehabilitation should be a key component in the majority of post-registration adult courses, including community nursing courses. The emphasis needs to move towards *doing nursing using rehabilitation principles.*

However, post-registration education must be flexible. Courses needed to be:

- easily available – the issues of funding and access are important, especially if the nurse works in a setting that is not designated as rehabilitation
- relevant – courses must give greater recognition to the skills of potential participants
- accessible through accreditation of prior experiential learning (APEL)
- offered at a range of levels including Masters level.

They should also formally acknowledge and incorporate flexible learning, portfolio building and work-based learning, including reflective practice.

The generic skills and knowledge summarised in Table 16.1 need to be taught and learned at a level of depth and application appropriate to the course and its participants. At the same time, there is a balance to be achieved between the continuing development of generic rehabilitation knowledge and skills and a highly specialist content. Some of the larger rehabilitation specialties, such as stroke care, may warrant specific courses or parts of a course. However, it is essential for the programmes to be sufficiently flexible to enable all students to identify and meet their individual learning needs.

16.5 Work-based learning

Learning in the workplace needs greater integration with formal educational provision. Some of the skills that nurses working in rehabilitation settings use are service or context specific. These have in the past been developed on an ad hoc basis, in response to service pressures, with little development of the underpinning knowledge base.

Work-based learning provides a valuable way of developing skills and knowledge pertinent to the local setting. As Barr's (2000) report on nearly 100 evaluations of interprofessional education concluded, it improves the quality of service and/or will have direct benefits for both services and clients. In the context of rehabilitation, it can provide a mechanism for helping practitioners working in the 'main' hospital to learn about the value and purpose of rehabilitation services and the nurse's contribution and role therein. Work-based learning is also the most appropriate place to develop teambuilding skills. It can provide the support and impetus to the generation of a local knowledge base on the nursing contribution. Indeed, participants at the nurses' workshop suggested that more systematic use of standardised assessment and outcome measures, or developing measures specific to nursing, could be a means of formalising often invisible nursing contributions.

However, within practice itself, working arrangements, shift patterns, and different responsibilities have provided substantial barriers to prevent nurses from participating in professional, in-service staff development and learning. More widely, unless specifically so directed, such training may not be for the whole team, both hospital and community staff and health and social care practitioners. Participants at the national expert workshops argued for organisational support and local facilitation to enable nurse participation, especially in multiprofessional team learning including multiprofessional journal clubs. Nurses, like therapists,

should be able to *'protect'* their time to ensure their own professional development, and not feel duty-bound to stay on the ward.

The research has identified implications for both nursing and therapy continuing professional development. In addition, learning about rehabilitation needs to recognised and valued by managers. They need to understand the nurse's role therein and the implications for staffing levels and mixes.

Finally, advantage can be taken of a range of other options to develop skills, knowledge and a wider understanding of rehabilitation in a range of settings. These include:

- rotational posts
- attachments
- clinical supervision
- lecturer-practitioner
- specialist nurse posts
- link nurse positions.

16.6 Mode of delivery: multi/interprofessional learning

As Miller et al. (1999) have shown, while interprofessional learning is generally perceived as a 'good thing', it is not systematically and consistently part of the professional education curriculum, and when undertaken it is more usual in post-registration programmes. In reality, student nurses work in teams from day one of their practice placements and many of those teams will be multiprofessional. As newly-qualified nurses, they may take up posts in rehabilitation services where there will be a range of expectations related to their role in the team that the majority presently feel ill-prepared to fulfil. Learning in multiprofessional teams may assist attempts to overcome the organisational, logistical and professional barriers to teamworking faced within practice.

Concerns were raised in the national expert workshops that having interprofessional learning too early in professional education might reinforce power imbalances between professions. The nurse may need to feel secure in the practice and theory of nursing before being exposed to education with other professions. However, the client experience may provide an alternative and most appropriate focus for interprofessional education. Indeed, some of the conflicts within the multiprofessional team may lie with the notion of expertise, that is, who is/are the 'expert/s' in rehabilitation. Vesting the notion of expert within the client and carer may provide an alternative and powerful focus for educational activity. The emphasis can then be on the client's need for a holistic, rehabilitative service, which is educative and empowering.

16.7 Concluding remarks

Finally, it is valuable to draw out a few comments on the implications of the above discussion for key stakeholders in rehabilitation and rehabilitation nursing education.

16.7.1 Modifying client expectations

More explanation and information, even client education, is needed to enable nurses to play their full role within rehabilitation. Expectations of *'doing for'* must be placed within the context of *'standing back'* and *'helping you to do it yourself'*.

16.7.2 Higher education institutions and trusts

Higher education institutions and trusts need to work in partnership in order for education to produce nurses who are fit for practice and able to improve the quality of service to clients (Department of Health, 1999a). Such a partnership must ensure that the relationship

between educational and practice development is one of dynamic progression rather than distance and dissonance.

16.7.3 Educators and practitioners

Rehabilitation nursing demands a complex range of skills and underpinning knowledge. Effective teamwork is as essential for the development of appropriate educational provision as it is for services to clients. It is at the point of practice that learning becomes real. Nurses and nurse teachers need to work with practitioners and educators from other rehabilitation professions to develop meaningful education experiences.

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Andrew Long
Rosie Kneafsey
Judith Berry
Julia Ryan
Rona Howard

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The higher incidence of chronic disease and disability has contributed to a growing recognition of the importance of rehabilitation services. There is also debate about the role, contribution and professional identity of the nurse within the multiprofessional and multi-agency rehabilitation team. This important research study consisted of an ethnographic study of three sets of contrasting case studies, national workshops and extensive interviews with nurses. The results have major implications for nursing education, in particular:

- the specific skills knowledge and competency areas for pre- and post-registration education
- the importance of learning in the workplace
- the need for learning about rehabilitation to be recognised and valued by managers.

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QUALITY EDUCATION FOR QUALITY CARE
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research HIGHLIGHTS

Exploring the role and contribution of the Nurse in the Multi-Professional Rehabilitation Team

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Abstract

This two year research study examined the role and contribution of the nurse within the multi-professional, multi-agency rehabilitation team by pursuing two questions: (1) how did the nurse, other members of the multi-professional team, the client and the carer perceive the nurse's actual and desired role? (2) how relevant did nurses find pre- and post-registration education in preparing them for their role in the rehabilitative team?

Information was gathered from: an ethnographic study of the rehabilitative career of a sample of clients with one of three conditions – fractured neck of femur, rheumatoid arthritis or stroke; and a set of four expert national workshops. Data sources included: observation of and interviews with clients, carers, nurses and other members of the multi-professional team and record review.

Six core nursing roles were identified relating to the areas of: assessment, co-ordination and communication, technical and physical care, therapy integration and therapy carry-on, emotional support, and involving the family. The extent to which all or any of these were taken forward depended on what was achievable within the particular situation. Changes in nurse education, both at pre- and post-registration level, are needed to adequately prepare the nurse for rehabilitation practice.

Main Findings

1. Fractured neck of femur

- Established working practices and routines guided the nursing care of clients with fractured neck of femur.
- Nurses fulfilled a key role in the initial and ongoing assessment of client needs. Other contributions included providing technical and physical care, integrating therapy into their nursing practice and carrying on with therapy, building up relationships with the client and carer, co-ordinating care and discharge planning.
- A shared focus on the restoration of mobility as the prime goal of rehabilitation aided multi-professional team working. As a result, rehabilitation was often equated with physiotherapy.
- Many nurses integrated the practice of mobility skills into everyday activities such as washing and dressing or using the toilet. This was often unrecognised or perceived as *routine*, as opposed to the *specialist* contribution of the physiotherapist.
- The age of the client often influenced judgements on the suitability of a client for access to dedicated rehabilitation settings.
- Although all clients were referred to the district nurses for 'routine care', district nurses were unclear about the rehabilitative component of their role.
- There were few instances of clients and carers being actively involved in goal setting, care planning or discharge planning.

2. Rheumatoid arthritis

- The emphasis in assessing needs, either in outpatients or on admission to hospital, lay on activities of living, developing a relationship with the client, carer and family, and deciding who to refer onto in order to take forward the rehabilitation process.
- The language used by nurses illustrated their approach to assessing client and carer needs. This centred on listening with key components of: asking, assessing, acting, explaining, giving information, reinforcing and reassuring.
- The nurse's contribution to meeting client and carer needs in rehabilitation ranged from assessment, providing care (physical, emotional and social) to helping with therapy, being a resource for the team and being busy (running the ward). In the hospital setting, some nurses felt that their responsibility for running the ward detracted from direct client contact.
- Nurses took a lead in co-ordinating the client's care to ensure that their needs were met. This involved ensuring correct referrals, preventing problems, providing direct care, building up a relationship with clients and their families, client education, discharge planning, encouraging the client and providing an information resource for the multi-professional team.
- The therapist saw the nurse's role in rehabilitation as centred on preparing the client for therapy, providing feedback and advice and carrying on therapy exercises.
- Some nurses found it hard to define their own role in rehabilitation, especially in a context of staff shortages (therapy and nursing), wider work pressures and a perception of the nurse as *'jack of all trades'*. There was evidence of the traditional rivalry between nursing, therapy and medical professions.

3. Stroke

- Nurses fulfilled a vital role in the initial and ongoing assessment of client need. Assessment was both formal and informal over a broad range of areas. Other contributions included providing physical help, emotional support, clinical nursing care, integrating therapy into activities of living, carrying on therapy treatments, and, to a lesser degree, involving family members.
- Nurses played a key role in co-ordinating care, ensuring referrals were made to other members of the team and providing information. Nurses acted as a 'buffer' between dissatisfied clients and carers and 'the system'. They tried to diffuse tensions and complaints. This was a tiring and unfulfilling part of nursing work.
- Qualified nurses delegated large amounts of physical care and hence integration of therapy to support workers or auxiliaries. However, support workers received limited amounts of instruction and guidance. In consequence, the extent to which rehabilitation principles and care plans were adhered to varied widely.
- Members of the multi-professional team were reliant on nurses' carrying on with their treatment plans, integrating them into everyday activities and providing feedback on progress. Without this, therapy staff felt that client progress would be hindered.
- Many members of the multi-professional team saw the nurse's ability to build a strong relationship with the client as a unique contribution.

4. Areas of unmet needs having a negative impact on the rehabilitative experience

- Across case study areas, clients and carers identified areas of unmet need: a lack of full and accurate information, a lack of involvement in decision making, a lack of social and emotional support, a lack of therapy and inadequate recognition of carer needs.
- Other areas of concern ranged from pain control, nutrition and pressure area care (fractured neck of femur), to medication, pain relief and involvement of the GP (rheumatoid arthritis) to experiences of routinised and ageist services (stroke).
- Clients suggested a lack of time, staffing shortages and 'burn out' as the main reasons for inadequacies in their care.

5. Ways to meet these unmet needs

- The majority of nurses were clear on how and why they would like their role in rehabilitation to develop. To a large degree these perceptions were consonant with those of the clients, carers and other members of the team.
- Both the nurse and other members of the rehabilitation team perceived the desired role of the nurse as embracing more time, more knowledge and a greater contribution in rehabilitation. Progress in each area would in turn meet the needs and expectations of clients and carers, especially for more individualised care.
- All members of the multi-professional team saw considerable benefit in nurses' developing extra rehabilitation skills and knowledge to enable therapy integration and therapy carry-on.
- The desired role included more time to spend on giving direct client care, to talk to clients and support clients and carers, and for the nurse to have a more integrated rehabilitation role.
- In each case study, nurses wanted to develop particular areas and skills. In fractured neck of femur, nurses pointed to a need for more specialist clinical skills for both physical care and rehabilitation. In rheumatoid arthritis, concern centred on improving the interface between the hospital and the community. In stroke care, nurses wanted greater responsibility for aspects of client assessment, for example, in assessing swallowing ability and potential in activities of living as a means of meeting gaps in therapy provision and improving client care.
- Nurses recognised the need for a consistent skills base throughout the entire multi-professional team and better team working. They desired greater recognition of the nursing contribution within the rehabilitation team.

6. Typicality of the findings

- Discussions in the four national expert workshops affirmed that the findings of the three case studies fitted with the participants' own experience, knowledge and practice within the rehabilitation area.
- The health and social care professionals

identified six general issues: the problematic valuing of rehabilitation and the nurse's contribution therein; the lack of recognition of the rehabilitative contribution within non-designated rehabilitation settings; the paucity of rehabilitation within the community; role hierarchy and role protectionism; the potentially wider role of generic support workers; and the need to involve clients and carers.

- Users and carers reinforced the case study findings, drawing attention *inter alia* to their need for information, encouragement, reassurance, continuity of care and involvement in care, and the nurse's valued role in providing emotional support, being a source of information and educating clients and carers.

Comparative Analysis of the Findings

1. The role and contribution of the nurse

- **An assessment role**: Typically, nurses performed an initial assessment, from which the nursing care plan was devised and first referrals made to other members of the multi-professional rehabilitation team. Nurses assessed over a wide range of areas including: the ability to self care; elimination; family and social support; medication; mood; nutrition; pain, pressure area and wound care; and social circumstances. Nurses considered other areas according to the client's diagnosis and morbid condition. Through their ongoing assessment, they provided up-to-date information for other team members. They were able to prevent potential problems, itself part of risk assessment, although the nurses did not describe it as such.
- **A co-ordination and communication role**: This embraced responsibility for a range of activities including gathering, synthesising and disseminating information, liaison, negotiation, and in the hospital setting running the ward and discharge planning. In both the hospital and community settings, nurses accessed services and the input of different practitioners on behalf of clients. This relied on good relations with other team members, an awareness of the clients' needs and the motivation to advocate for clients and carers. In the hospital setting, nurses provided vital information feedback to therapy staff on the clients' progress with areas such as mobility, transferring and positioning or other activities of living, as well as how clients were responding to treatments. This information enabled therapy staff to adapt their care plans to suit the individual.
- **Providing technical and physical care**: This was perceived as an expected contribution by nurses and other team members. In the community setting, the nurse's contribution to the provision of technical care had grown, to the exclusion of many aspects of physical care. The lack of involvement in providing physical care precluded the integration of physical and emotional forms of 'therapy' into activities of living. In the hospital, ensuring the client's physical care needs were met comprised a large part of the nurse's so called routine work. More often than not, however, the nurse delegated to auxiliary/support workers who carried out the majority of physical care.
- **Integrating therapy and therapy carry-on**: The nurse's role in therapy integration and therapy carry-on required the nurse to adopt the philosophy and practice of rehabilitation, and additional skills and knowledge. Therapy carry-on had a limited focus. It involved nurses carrying out 'prescribed' therapy exercises, or instructions with clients, such as supervising swallowing exercises or passive exercises, using heat or cold packs, or using splints. Therapy integration was broader, with two inter-connecting aspects: (1) the nurse's attempts to create an environment which itself was therapeutic and facilitated rehabilitation, seeking ways to minimise physical, emotional and social barriers to rehabilitation; (2) the nurse building on the work of the therapists. Examples included: taking the time to use the correct transferring or positioning techniques when getting in or out of bed; coaching and supervising the client going to the table; using the same techniques as the occupational therapist when washing and dressing in the morning or at night. In the stroke and fractured hip case studies in particular, many nurses wished to expand their role in the provision and reinforcement of therapy in order to ensure better continuity of client care and more effective rehabilitation. This was supported by other team members and by clients and carers who wanted more therapy.
- **Providing emotional support**: This role was considered by many practitioners to be a special and unique nursing contribution. Clients and carers frequently praised the personal characteristics of individual nurses. More often this was an informal activity discussed verbally. In the rheumatoid arthritis case study, the term empowerment was frequently mentioned. In the stroke and fractured hip case studies, nurses tried to find out about clients and carers worries and fears, providing advice or reassurance where appropriate. Nurses continually noted the lack of time to provide emotional care.
- **Involving the family**: The nurse's attempts to involve the client's family formed part of their activities of providing information, emotional care, communication and co-ordination. As the most accessible practitioner and the member of staff clients were most accustomed to, nurses by default were often viewed as the first port of call, when seeking information or advice. This was the case both in the hospital and the community.

2. Factors affecting the role and contribution of the nurse

- Client and carer expectations of the nurse as someone who *'does for'*, could affect the nursing contribution and the behaviour of the client. Qualified nurses and support workers tried to temper the tradition of *'doing for'*, with a *'standing back'* approach in order to work in a rehabilitative manner.
- Even in the specialised rehabilitation units, time constraints, work priorities, and skills were crucial hindrances to the nurse working in a rehabilitative and individualised way. Nurses felt they were forced to approach their work as a series of tasks to achieve in a set time.
- Many nurses working in rehabilitation settings felt devalued and under-recognised. They also

perceived a need for greater knowledge and skills.

- The nursing contribution and role in the rehabilitation can be characterised as an emphasis on *'the achievable'*. Some, if not all, nurses espoused a broad conception of rehabilitation. The extent to which they were able to integrate rehabilitation principles into care delivery was dependent *inter alia* on staffing and skill mix, others' valuing the nurse's role and client and carer expectations.
- Differences in the nursing contribution to rehabilitation were notable across settings. Nurses in acute settings (and in some instances, in general rehabilitation areas) were not always aware of their contribution to rehabilitation. This contrasted with nurses working in specialist rehabilitation teams who had a clearer concept of their role in rehabilitation. In the more specialised stroke units nurses were more confident in their abilities to contribute to both therapy integration and therapy carry-on.
- District nurses identified changes in their role in rehabilitation, with it being less well recognised and utilised. Nurses in the continuing care setting identified the growing potential of their role in rehabilitation.

3. Implications for nursing practice

- The findings on client and carer unmet needs highlight the need for service users to be at the heart of the rehabilitation process.
- Ways to improve the nursing contribution to rehabilitative care relates to the nurse having time, more knowledge and skills and the occurrence of better team working.
- In the hospital setting, nurses desire reciprocal sharing of some activities amongst the whole team, rather than only nurses taking on new roles. Nurses' continuous presence on the ward, compared to the therapists' relative scarcity, largely precludes this.
- Exploring the dynamics of rehabilitation teams highlight the need for nurses to be recognised and for themselves to recognise, value and feel more confident in their knowledge and skills. Changes in perceptions within and beyond the nursing profession are required.

4. Educational preparedness for the role in the rehabilitative team

- Only 36% of respondents to the postal questionnaire (57% response rate) thought that in retrospect their pre-registration education had provided them with adequate skills and knowledge for their role in rehabilitation. A lack of focus on rehabilitation *per se* and on needed clinical skills was noted.
- Most (71%) nurses had attended an educational or training course relevant to their role in rehabilitation in the last five years. Over half (58%) would like to attend other such courses or study days. There were difficulties in attending relevant courses and funding.
- A variety of other methods for keeping up-to-date and learning about rehabilitation were mentioned, in particular: in-service training; learning by experience and from colleagues; reading journals; membership of practice associations or specialists groups; and doing projects to develop practice.
- Nearly two thirds (65%) of respondents indicated areas of their current role in rehabilitation they would like to change or learn about. Areas of change ranged from developing the nurse's role and having more time / staff, to playing a greater role in the team. Perceived learning needs related to more understanding of the specific clinical conditions, the whole process of rehabilitation, the contribution of other team members, wider care outwith the hospital, psychological care and pain management.
- Better education would lead to better client care. Enhanced confidence was noted and a need for a consistent skill base throughout the nursing team.
- Therapists identified gaps in nursing knowledge and skills covering their ability to carry on the work of therapists and nursing care being informed by the philosophy and principles of rehabilitation. Emphasis lay on the nurse learning from the therapist.

5. Implications for nursing education

- The knowledge base required for effective nursing practice in rehabilitation is wide and complex. Teaching should be driven by a social model of rehabilitation, recognising its role within health and wellness as well as in disability and illness, and prioritising the client and carer perspective.
- Specific skills, knowledge and competency areas can be identified for both pre- and post-registration education. These include: awareness of the client and carer perspective; chronic disease; creating a therapeutic environment; listening and communication skills; motivational skills; normal ageing; rehabilitation in the community; and risk assessment. As team working is fundamental to rehabilitation practice, it should be at the core of rehabilitation education.
- Underlying all of the above is the essential need for the nurse to have a full understanding of the philosophy, principles and models which underpin rehabilitation, the impact these have on service delivery and the client's experience of care.
- Within pre-registration education, rehabilitation should be an ongoing thread throughout the entire curriculum. Integration could mean invisibility and thus a dedicated module may be needed.
- At post-registration level, a nationally recognised and accredited post-registration qualification in rehabilitation is essential. Post-registration courses should be multi-professional, involving all members of the team and, where possible, medical staff.
- Learning in the workplace needs to be integrated with more formal educational provision. Organisational support and local facilitation is required to enable nurse participation, especially in multi-professional team learning, including multi-professional journal clubs.
- Learning about rehabilitation also needs to be directed at managers. They need both to recognise and value the importance of rehabilitation, and to understand the nurse's role therein and implications for staffing levels and mixes.

Methods

The study adopted a two phased design (see Figure 1, below). Phase One comprised an ethnographic study of sets of contrasting case studies. The case studies were chosen for variability in terms of settings (primary, secondary and continuing care), client need and potential nursing role (fractured neck of femur, rheumatoid arthritis and stroke). The client's experience of rehabilitation provided the observational window through which the role and contribution of the nurse was explored. Settings were chosen to represent generalist and specialist rehabilitation provision and client pathways with potential transitions between primary, secondary and continuing care.

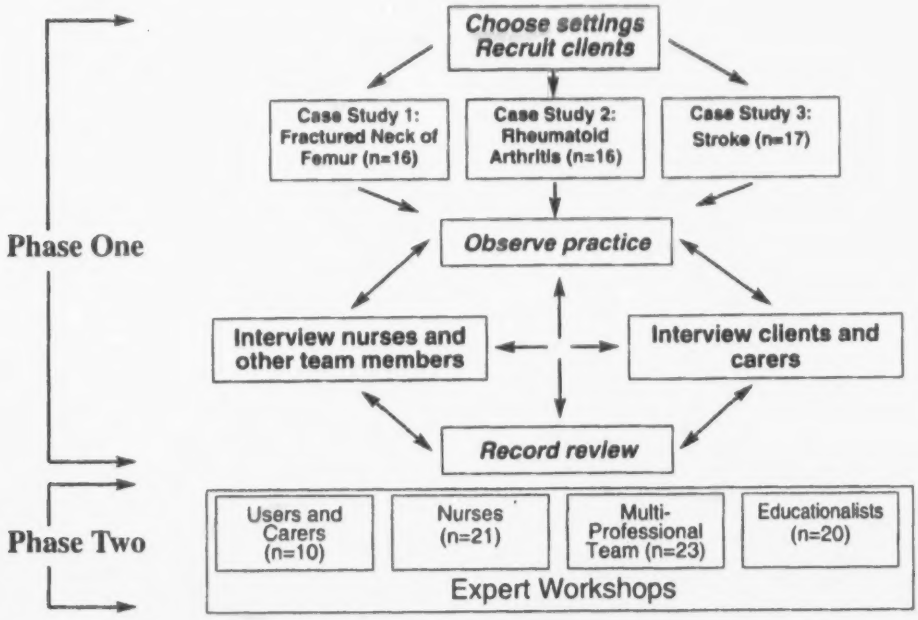
Forty-nine clients were recruited, with informed consent, each chosen purposively using the approach of theoretical sampling, ensuring variation in age, gender and severity of condition. They were followed for part of their rehabilitative career for up to six months. Data collection involved: observation of settings, events and interactions; interviews of clients, carers and staff; think-aloud with nursing staff; staff questionnaire; and record review. Data analysis was ongoing and based on the approach of grounded theory, identifying and attaching codes and categories and isolating more general abstracted categories and themes for generalisation.

Adopting a case study approach with fieldwork undertaken in one NHS region is potentially problematic in providing findings for a study with national interest. Two approaches were used to address this issue. The first, outlined above, involved the choice of 'typical' conditions, settings and 'representative' users and then identifying contrasting settings, user characteristics and their pathways through rehabilitation services, using the approach of theoretical sampling. The second involved undertaking a series of four national 'expert' workshops with four groups: users, carers and carers' organisations; nurses; members of the multi-professional, multi-agency team; and educationalists. Each invitee had to meet at least one of the following:

- Representative of key stakeholder group
- Knowledgeable in the area - either through practice (ill-health, work) and/or research
- Come from a location / organisation with credibility and/or good practice / reputation
- Able to provide a perspective from another NHS region to that in which the fieldwork was conducted.

Ethical approval was obtained from the appropriate Multi-Centre Research Ethics Committee and from each of the selected Trusts Local Research Ethics Committees.

Figure 1: Overview of Study Design



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Details about the Project

In January 1998, the English National Board for Nursing, Midwifery and Health Visiting (ENB) commissioned a multi-disciplinary research team at the University of Salford to undertake a two year study of the role and contribution of the nurse within the multi-professional, multi-agency rehabilitation team. A two phased design was undertaken, comprising an ethnographic study of a set of contrasting case studies and four national expert workshops. The findings have significance for a range of groups: practising nurses (in clarifying the nature of a potential role and reflecting on their own practice); other members of the rehabilitation team (in recognising the nature and potential of the nurse's role and enabling its full potential to arise); nurse and other managers (to recognise what rehabilitation comprises and staff implications); higher education institutions (in designing and delivering pre- and post-registration education); and, not least, clients and carers (in enabling and supporting nurses to *'stand back'* and *'help you do it for yourself'*). The Final Report (ENB 2001) provides detailed descriptions of the nurse's role from the multiple perspectives of key stakeholders within each of the three case study conditions (fractured neck of femur, rheumatoid arthritis and stroke), a comparative analysis of the role and contribution of the nurse, and insight into the relevance of pre- and post-registration education for the nurse's role within the multi-professional team.

Final Report

The final report "Teamworking in Rehabilitation: exploring the role of the nurse" will be published in June 2001. Copies may be obtained through the Publications Department of the ENB listed above.

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